

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2194

02172

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville Md.</u>				c. LENGTH OF STAY IN 1b <u>15 mos</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1512 Chillum Road</u>				d. STREET ADDRESS <u>1512 Chillum Road</u>			
3. NAME OF DECEASED (Type or print) <u>John DULANEY Ames</u>				4. DATE OF DEATH Month <u>2</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-1902</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Broker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balt. more, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edgar A. P. Ames</u>				14. MOTHER'S MAIDEN NAME <u>Susan Elizabeth Eader</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Lillian Mae</u> Address <u>same address (wife)</u> <u>Mrs. Ames</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> " <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>July 10, 1958</u> to <u>July 13, 1961</u> ; that (I) ( <del>we</del> ) last saw the deceased alive on <u>Sept. 10, 1960</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert F. Dyer</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>ROBERT F. DYER, M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1835 Eye St. NW Wash. D.C.</u>		22b. DATE SIGNED <u>2/13/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hines Co.</u>				ADDRESS <u>2901 14th NW</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1150

1015

3

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. The text appears to be organized into several paragraphs.]*

①

## 2195

# CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMP SPRINGS</b>		c. LENGTH OF STAY IN 1b <b>X MONTHS XXXX DAYS</b> <b>CAMP SPRINGS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP ANDREWS</b>		d. STREET ADDRESS <b>7603 MORRIS AVENUE</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ROBERT RETTIG ANDERSON</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>10</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11 JUN 1908</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRAINING OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT C. S.</b>	
11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>--</b>		14. MOTHER'S MAIDEN NAME <b>RUTH SWENON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES W. W. 2</b>		16. SOCIAL SECURITY NO. <b>213-38-7324</b>	
17. INFORMANT <b>COY SEVIER LT COL USAF</b>		Address <b>AAFB</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO <b>CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 15 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 FEB 19 61</b> to <b>10 FEB 19 61</b> , that (I) (we) last saw the deceased alive on <b>10 FEB 19 61</b> , and that death occurred at <b>4:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew W. Butchko</b> M.D.		22b. DATE SIGNED <b>11 FEB 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANDREW W. BUTCHKO CAPT USAF MC</b>		22d. ADDRESS <b>USAF HOSP AAFB CAMP SPRINGS, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/11/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Milton Mills Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Milton Mill, Hampshire New</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

11 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2196

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02174

1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Prince George's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i>				c. LENGTH OF STAY IN 1b <i>1 1/2 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Prince George's General</i>				d. STREET ADDRESS <i>13516 Dean Drive</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>Baranski</i>		Last <i>Baranski</i>		4. DATE OF DEATH Month <i>2</i> Day <i>25</i> Year <i>1961</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>2-25-61</i>		9. AGE (In years lost birthday) <i>—</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i>	IF UNDER 24 HRS. Hours <i>+</i> Min. <i>30</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Prince Geo Co - Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lawrence H. Baranski</i>				14. MOTHER'S MAIDEN NAME <i>Irene Blanche Uliniski</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bilateral Pulmonary Embolism</i> 761.5 DUE TO <i>Prematurity</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <i>Premature Rupture of Membranes 25 weeks</i> (c) <i>Premature Rupture of Membranes 25 weeks</i>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 25</i> 1961, to <i>Feb 25</i> 1961, that (I) (we) last saw the deceased alive on <i>Feb 25</i> 1961, and that death occurred at <i>2:20</i> PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Francis Warren</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Dr. Francis Warren</i>				22d. ADDRESS <i>6805 Baltimore Ave. College Park, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Feb 27, 1961</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City, town, or county) (State) <i>Montgomery Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur L. Howard</i>				ADDRESS <i>254 Carroll St NW DC</i>		25a. REC'D BY REGISTRAR <i>Arthur L. Howard</i>	
				DATE <i>FEB 28 '61</i>		25b. REGISTRAR'S SIGNATURE	

0077215XVO

1891

RECORD OF DEEDS

111

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02175

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Upper Marlboro		d. STREET ADDRESS J	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Barbara Jean Barnett				4. DATE OF DEATH Month Day Year February 3 19 61			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 8, 1958 2 yrs.	
9. AGE (In years last birthday) Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James Nathaniel Barnett		14. MOTHER'S MAIDEN NAME Barbara Jean Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Barbara Jean Barnett, Same as 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal first, second and third degree burns 916-9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In a room that had an oil stove that caught on fire					
20c. TIME OF INJURY Month, Day, Year 12:15 p.m. 2 / 3 / 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P. G. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL-SIGNATURE EXAMINER'S NAME (Type) James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 2/3/61		Address (Street, city, town, or county) xxxxx					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 2-7-61		22c. NAME OF CEMETERY OR CREMATORY Mason		22d. LOCATION (City, town, or country) (State) Upper Marlboro Md	
23. FUNERAL DIRECTOR Address Harry S. Washington & Sons 4925 Gleason Ave NW		24a. REC'D BY REGISTRAR DATE FEB 8 '61		24b. REGISTRAR'S SIGNATURE Arthur L. House			

MEDICAL CERTIFICATION

1915

1915

1915



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2198 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02176

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Nathaniel Barnett				4. DATE OF DEATH Month Day Year February 3 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1956 4 yrs.	
9. AGE (in years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James Nathaniel Barnett				14. MOTHER'S MAIDEN NAME Barbara Jean Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs Barbara Jean Barnett, same as 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal first, second and third degree burns DUE TO (b) 915.0 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In room in which a stove caught on fire			
20c. TIME OF INJURY Month, Day, Year 12:15 p.m. 2 / 3 19 61				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home				20f. (City & town, County) Upper Marlboro P. G. Md			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2/3/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) 2-7-61				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY Mason				22d. LOCATION (City, town, or country) (State) Upper Marlboro Md			
23. FUNERAL DIRECTOR Henry S. Washington & Son 4925 Deane Ave NE				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
				DATE FEB 8 '61			

MEDICAL CERTIFICATION

M

X

✓

0

16

2

RECEIVED  
JAN 10 1902  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

FROM THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

FROM THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

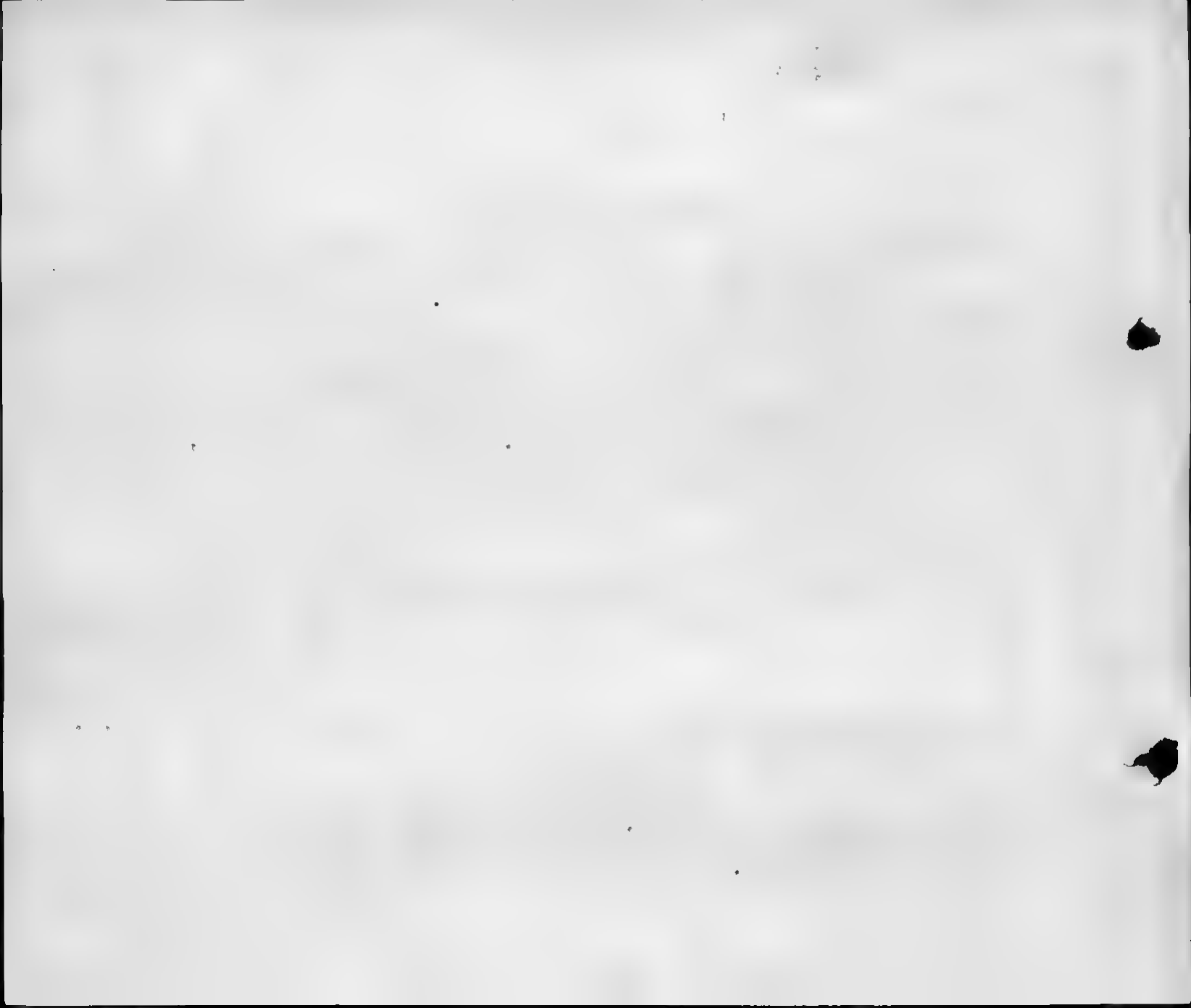
FROM THE SECRETARY OF AGRICULTURE  
WASHINGTON, D.C.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**2199 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02177

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro			
c. LENGTH OF STAY in 1b Life				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year	
Melvin Clyde Barnett				February 3, 19 61			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 28, 1957	9. AGE (In years, days, months, days, hours, min.) 3 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY one		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Nathaniel Barnett				14. MOTHER'S MAIDEN NAME Barbara Jean Kelly			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Bragara Jean Barnett, same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal 1st, second and third degree burns							
DUE TO (b) Conditions, if any, which gave rise to immediate cause (c) DUE TO (c) stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) In a room that had an oil stove that caught on fire					
20c. TIME OF INJURY Month, Day, Year 2:15 PM 2/3/ 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Upper Marlboro P.G. Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd				DATE SIGNED 3 2/3/61			
EXAMINER'S NAME (Type) James I. Boyd				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. SERIAL, CREMATION, REMOVAL (Specify) 2-7-61				22b. DATE THEREOF 2-7-61			
22c. NAME OF CEMETERY OR CREMATORY Maus				22d. LOCATION (City, town, or country) (State) Upper Marlboro Md			
23. FUNERAL DIRECTOR Penny Washington				24a. REC'D BY REGISTRAR 4925 - please one ms			
24b. REGISTRAR'S SIGNATURE Arthur S. Kline				DATE FEB 8 '61			



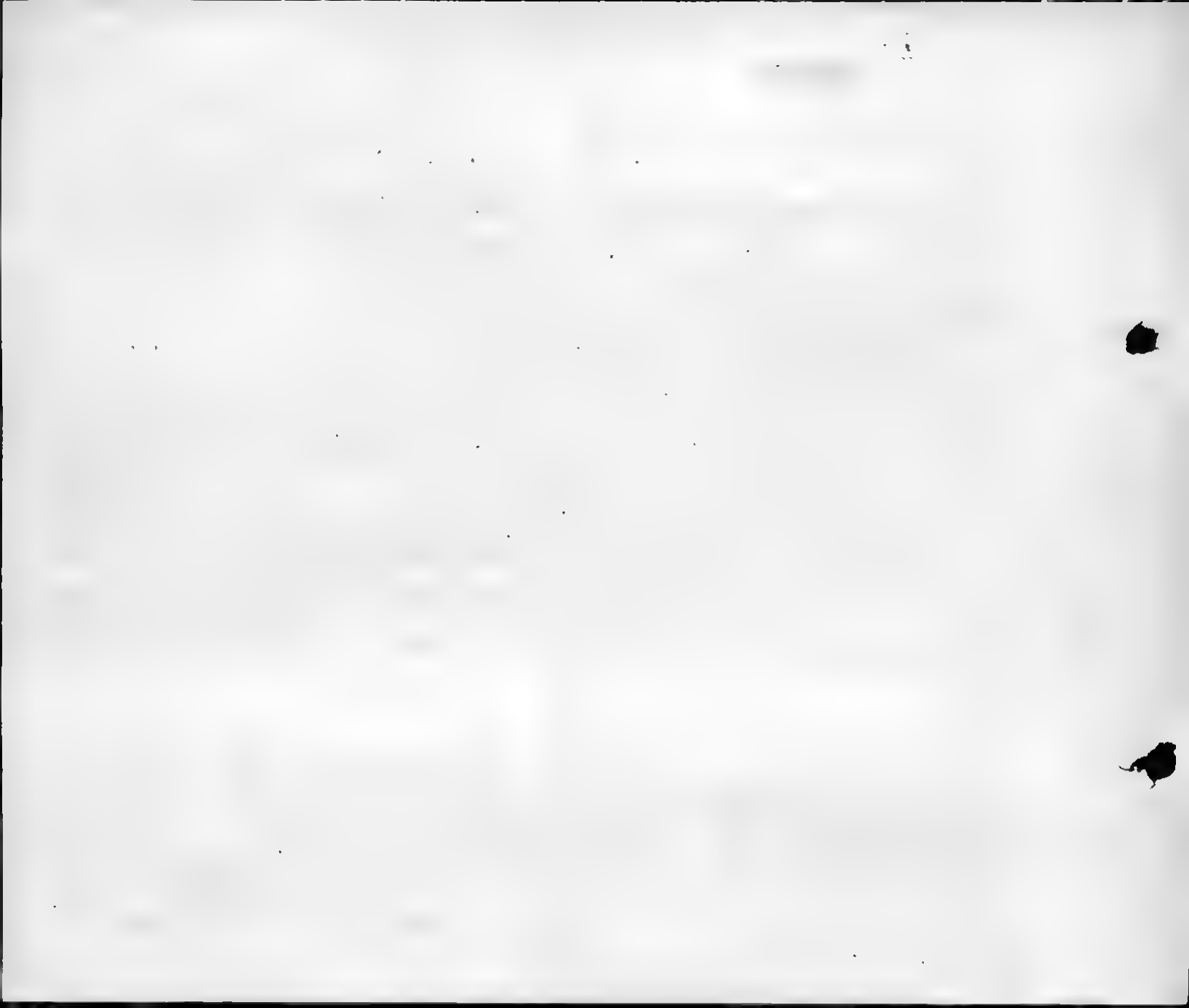
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02178

2200

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>1 Hr. 20 Min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Rainier</b> <b>47</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>4409 30th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Jessie</b> Middle <b>L.</b> Last <b>Battley</b>		4. DATE OF DEATH		Month <b>February</b> Day <b>15</b> Year <b>19 61</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-30-1898</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		11. IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Leicester, N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James Edwards</b>				14. MOTHER'S MAIDEN NAME <b>Cora Casada</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>None</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John P. Battley, Husband</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>4200</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Occlusion of Right Coronary Artery</b> DUE TO <b>Coronary Arteriosclerotic Heart Disease</b> (c) <b>Coronary Arteriosclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>hours</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1960</b> to <b>Feb 15, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 15, 1961</b> , and that death occurred at <b>5:28 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon R. Levitsky</b>				22b. DATE SIGNED <b>2/15/61</b>			
22c. PHYSICIAN'S NAME (Type) <b>LEON R. LEVITSKY</b>				22d. ADDRESS <b>3408-R.I. AVE. MT. RAINIER, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City town or county) (State)	
<b>Burial</b>		<b>2/18/61</b>		<b>Fort Lincoln Cemetery</b>		<b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home, Inc.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 20 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Khand</b>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

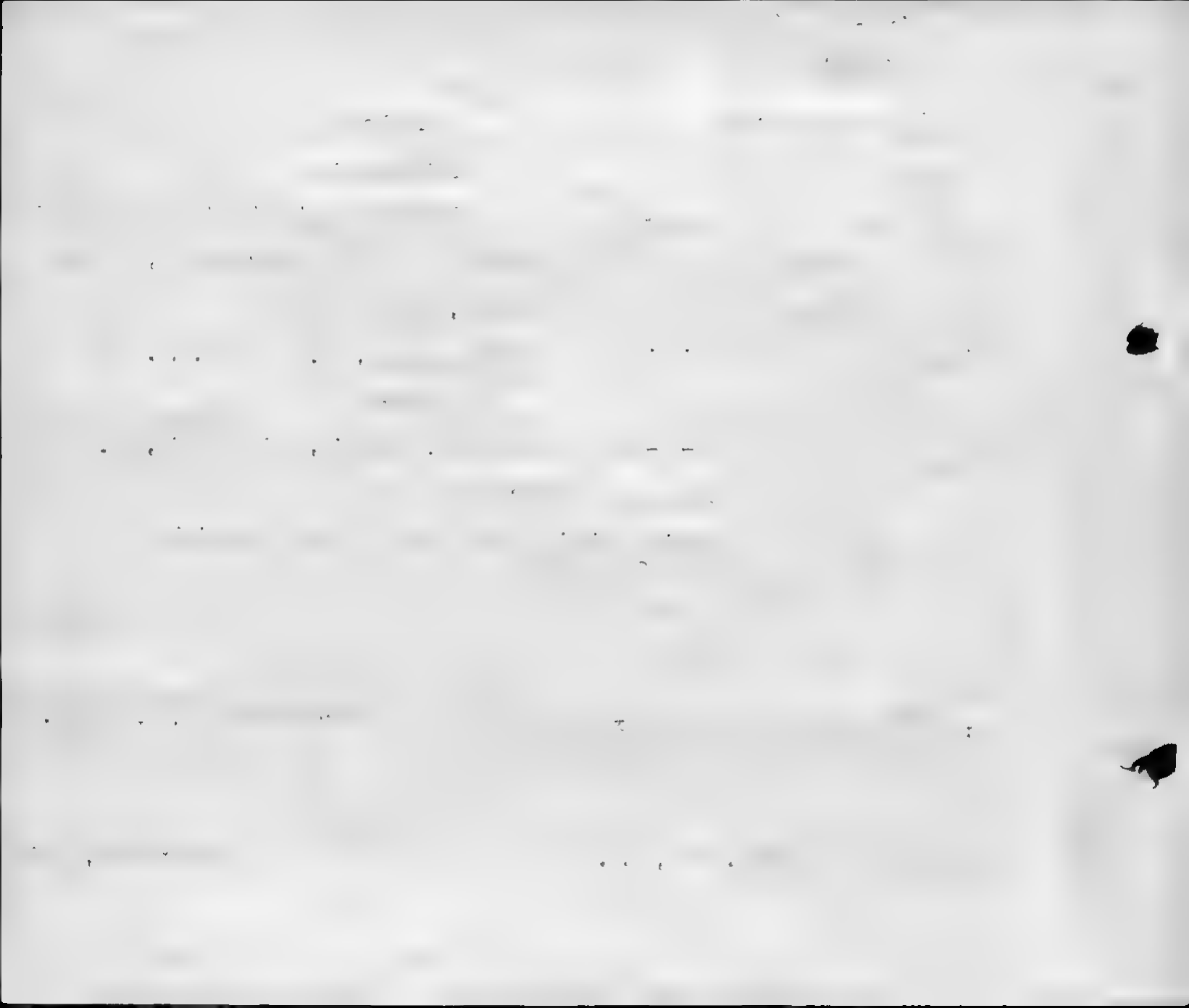
VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0217

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>Philadelphia</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b>		d. STREET ADDRESS <b>1428 South 10th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DANIEL JOSEPH BELANCIO</b>		4. DATE OF DEATH Month Day Year <b>February 2, 1961</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Month Day Year <b>July 27, 1903</b>		9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Girard Belancio</b>		14. MOTHER'S MAIDEN NAME <b>Mary Chusso</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>180-14-4824</b>		17. INFORMANT <b>Salvatore F. Belancio, Philadelphia, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Crushing injuries to the head body and extremities multiple and severe</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Passenger in a train that was in a wreck</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in a train that was in a wreck</b>		20c. TIME OF INJURY Month, Day, Year <b>1:00 p.m. 2/2/ 1961</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Train</b>		20f. (City or town) (County) (State) <b>Jerricho Park P. G. Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <b>James I. Boyd</b>		22. DATE THEREOF <b>FEB 6, 1961</b>		23. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS</b>		24. LOCATION (City, town, or country) (State) <b>YEADON DEL CO., PENNA.</b>		25. REC'D BY REGISTRAR <b>FEB 8 '61</b>		26. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		27. EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		28. DATE SIGNED <b>February 2, 1961</b>		29. ADDRESS (Street, city, town, or country) <b>W. W. Chambers Co., Riverdale, Md.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2202

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

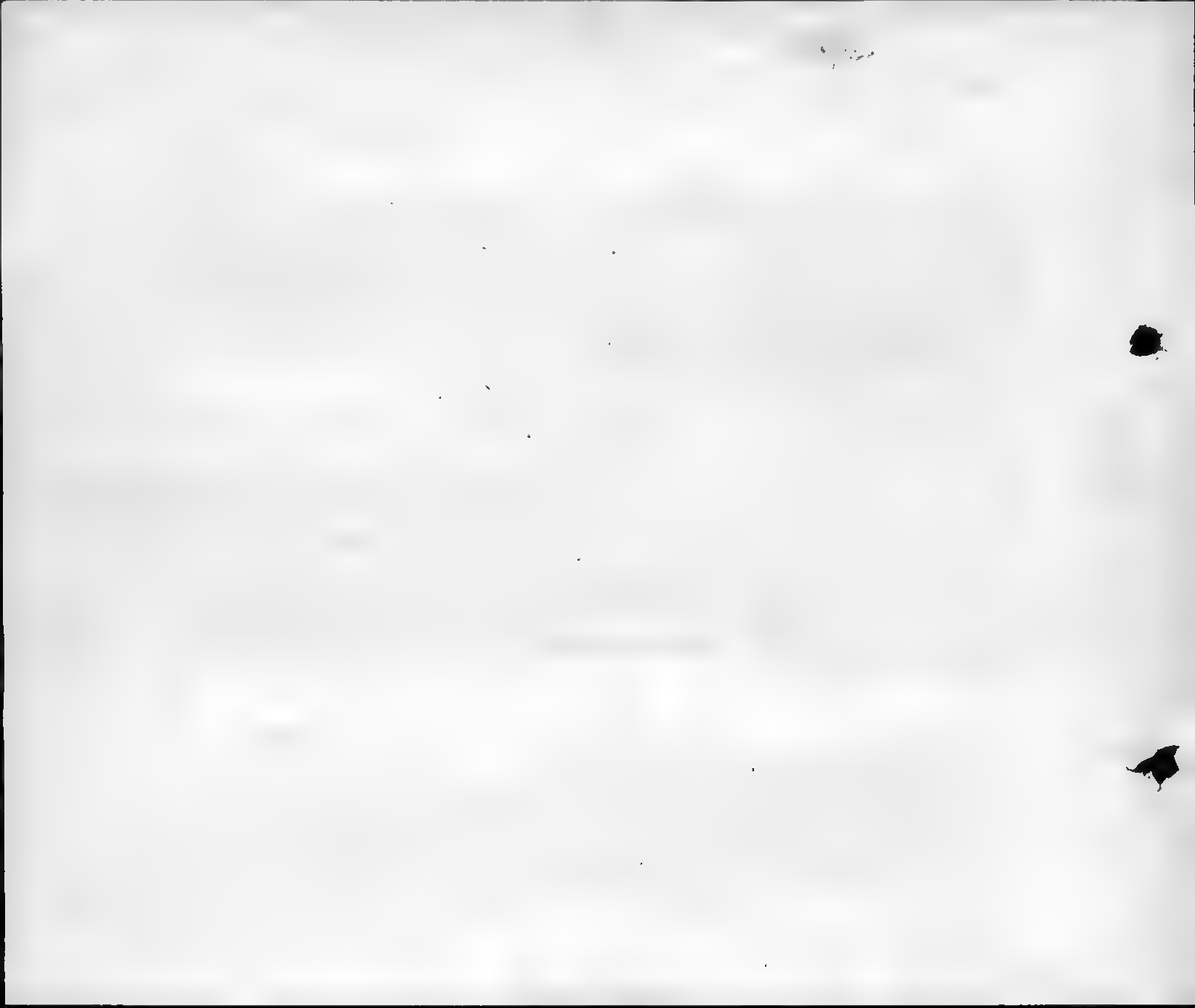
CERTIFICATE OF DEATH

Item 9 Firm 2202 3-2-61 et

02180

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b> d. STREET ADDRESS <b>507 62nd Pl.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>W.</b> Last <b>Belk</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-10-92</b> 9. AGE (In years birthday) <b>68</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORATORY TECH.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FEDERAL GOV'T</b>	11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>ALONZA BELK</b>	
14. MOTHER'S MAIDEN NAME <b>LOUISA ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MARTHA C. BELK</b> Address <b>507 62nd Place</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>many years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>February 9, 1961</b> to <b>February 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 24, 1961</b> , and that death occurred at <b>7:45</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>Thomas Edison</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>THOMAS EDISON</b>		22d. ADDRESS <b>1015 Spring St., Silver Spring, Md</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>3-1-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY NAT'L PARK</b>	23d. LOCATION (City, town, or county) (State) <b>CHAPEL OAKS, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Alex S. Pope</b>		25a. REC'D BY REGISTRAR <b>FEB 27 '61</b>	
ADDRESS <b>414-15th St., S.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**2203**

**02181**

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Prince George</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u> c. LENGTH OF STAY IN 1b  d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belmont Memorial Hospital</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>01 Laurel, Md</u> d. STREET ADDRESS <u>1328 Prince George St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Stella</u> Middle <u>A.</u> Last <u>BENNIE</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>21</u> Year <u>1961</u>		<b>5 SEX</b> <u>Fe</u>		<b>6 COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <u>5-2-08</u>		<b>9 AGE</b> (In years lost birthday) <u>52</u> yrs.		<b>10 IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11 IF UNDER 24 HRS</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pennsylvania</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Alexander Washeleski</u>								<b>14. MOTHER'S MAIDEN NAME</b> <u>Stella Mendolashi</u>											
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>				<b>16. SOCIAL SECURITY NO</b> (If yes, give war or dates of service)				<b>17. INFORMANT</b> Address											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>																			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>																			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. _____ p. m. _____ _____ 19____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)							
<b>21 I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above</b>																			
<b>22a. SIGNATURE</b> <u>Charles House</u>								M. D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				<b>22b. DATE SIGNED</b> _____							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>CHARLES HOUSE</u>								<b>22d. ADDRESS</b> _____											
<b>23a. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/24/61</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>St Mary Cemetery</u>				<b>23d. LOCATION (City, town, or county)</b> (State) <u>Laurel Md</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>DeWitt Canalehan</u>								ADDRESS <u>Laurel Md.</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 1 '61</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Foyard</u>			





2204

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

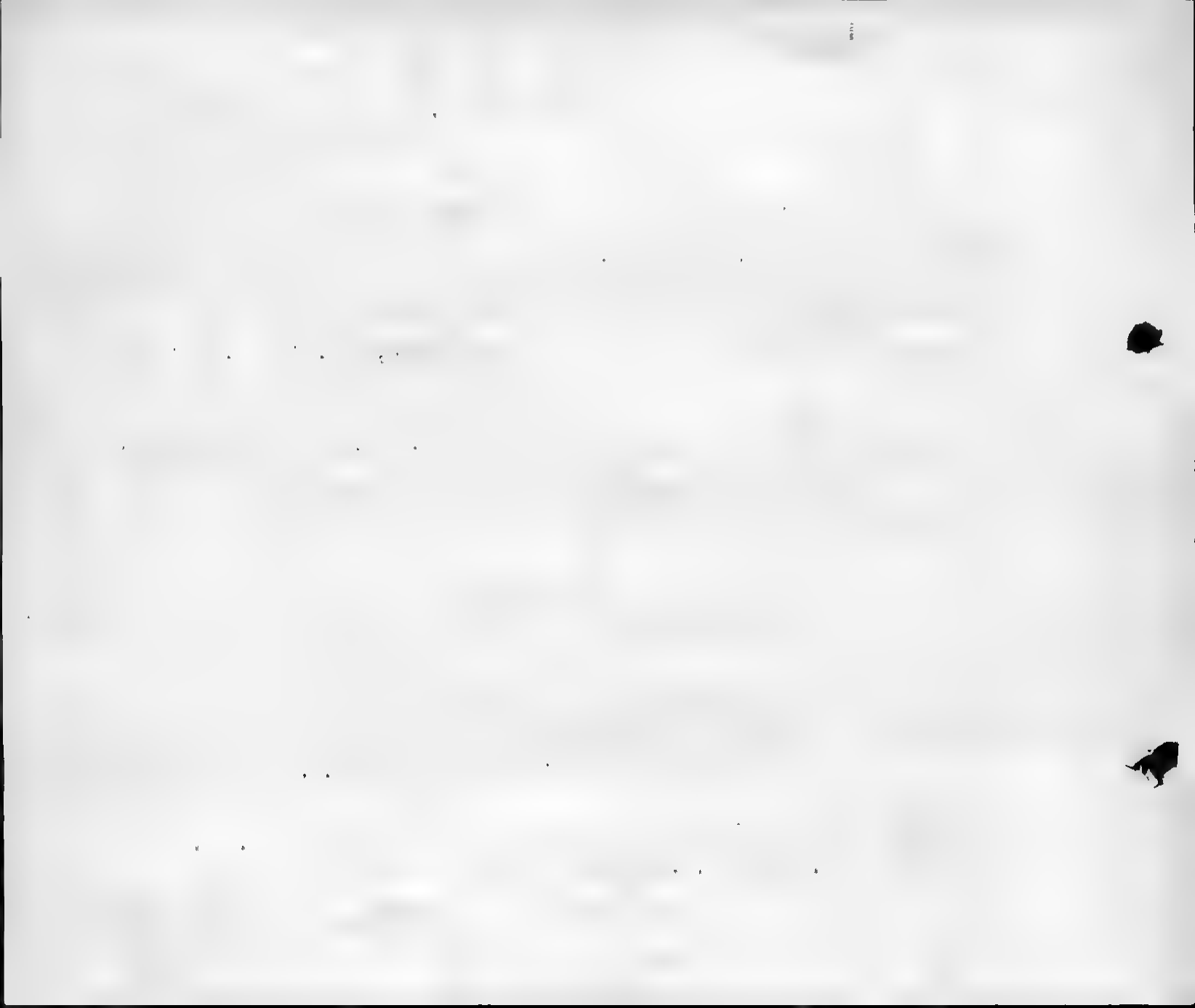
CERTIFICATE OF DEATH

Item 14 Fairview 2-9-61 et

02180

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence Before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wd/ Cheverly</b>		c. LENGTH OF STAY IN 1b <b>12 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
f. STREET ADDRESS <b>2007 Oglethorpe</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henrietta</b> Middle <b>C.</b> Last <b>Berkley</b>		4. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-9-90</b>
9. AGE (In years last birthday) <b>70</b> yrs		10. IF UNDER 1 YEAR Months <b>10</b> Days <b></b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>WASHINGTON, DIST. OF COL.</b>	
11. BIRTHPLACE (State or foreign country) <b>UNITED STATES</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>FRANCIS CLAVELUX</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Wise</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT (Son) <b>MR. WILLIAM N. BERKLEY</b>		Address <b>ROUTE #4-VIENNA, VIRGINIA</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Upper Marlboro. Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 23, 1961</b> , to <b>Feb. 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 3, 1961</b> , and that death occurred at <b>11:45 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Robert B.G. Sasser</b>		22b. ADDRESS <b>Upper Marlboro. Md.</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert B.G. Sasser</b>		22d. ADDRESS <b>Upper Marlboro. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/8/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CATHOLIC CEMETERY</b>	
23d. LOCATION (City, town, or county) <b>HANOVER, PENNSYLVANIA</b>		23e. LOCATION (City, town, or county) <b>HANOVER, PENNSYLVANIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nysong Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 6 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

Wash. D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

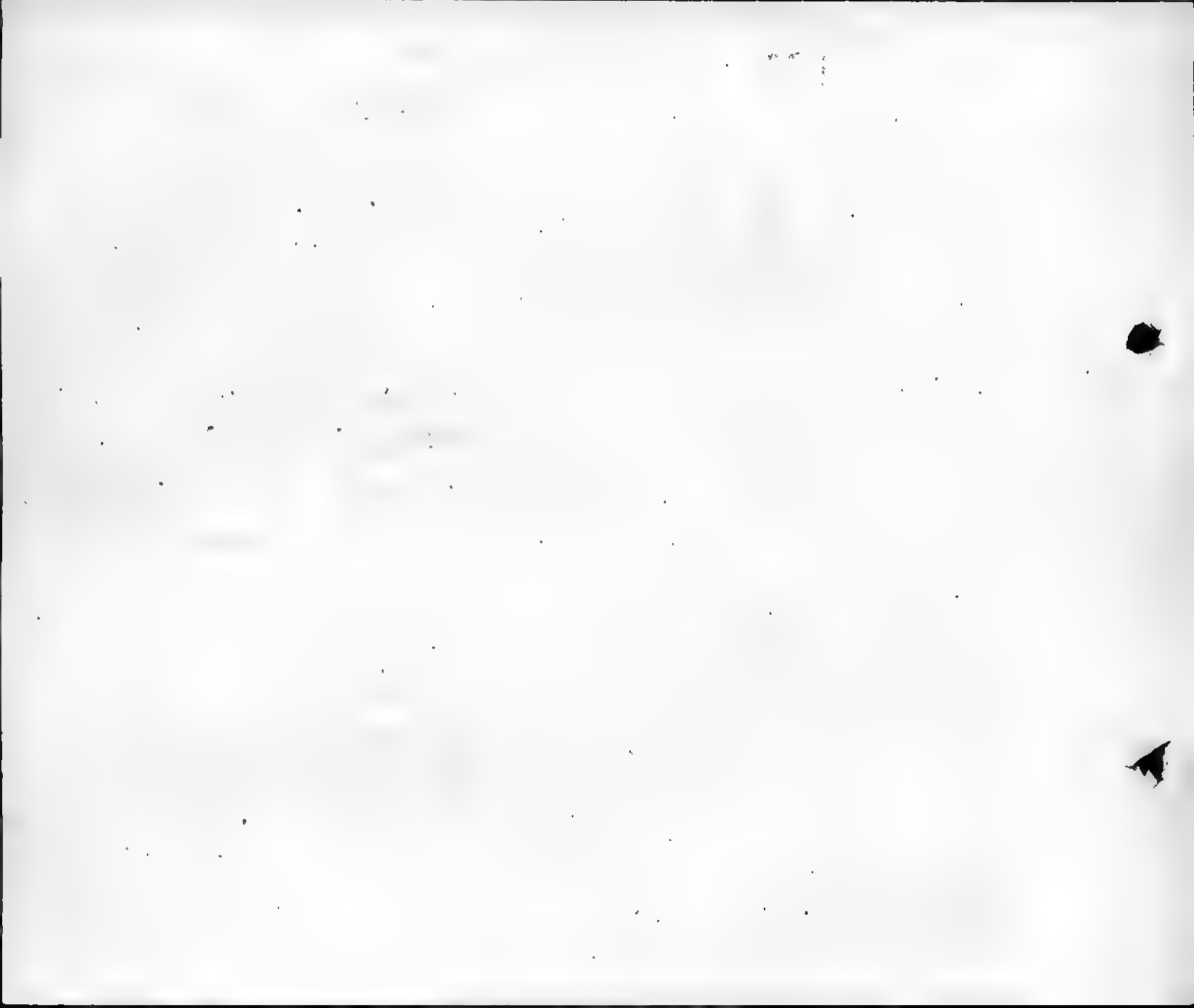
2205

CERTIFICATE OF DEATH

Reg. Dist. No. 02183

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u> adm 2-9-50		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>		d. STREET ADDRESS <u>LAKE DRIVE APTS.</u>	
3. NAME OF DECEASED (Type or print) <u>CECEE F. BERNATH</u>		4. DATE OF DEATH <u>FEBRUARY 14</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 1, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (in years last birthday) <u>87</u> yrs
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>not known</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE TERDENHEIMER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4:20.0</u> DUE TO <u>hypostatic pneumonia</u> Conditions if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>arteriosclerotic heart disease</u> lying cause lost. (c) <u>several yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>several days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis with psychosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>Feb 14</u> , 19 <u>61</u> that I last saw the deceased alive on <u>2-14</u> , 19 <u>61</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Erika P. Kraemer</u> M.D.		DATE SIGNED <u>LAUREL SANITARIUM 2-14-61</u>	
PHYSICIAN'S NAME (Type) <u>ERIKA P. KRAEMER</u>		<u>LAUREL MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-16-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eastern Pl</u>		24a. REC'D BY REGISTRAR <u>Feb 15 '61</u> 24b. REGISTRAR'S SIGNATURE <u>C. Lewis &amp; Kenna</u>	

(I)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

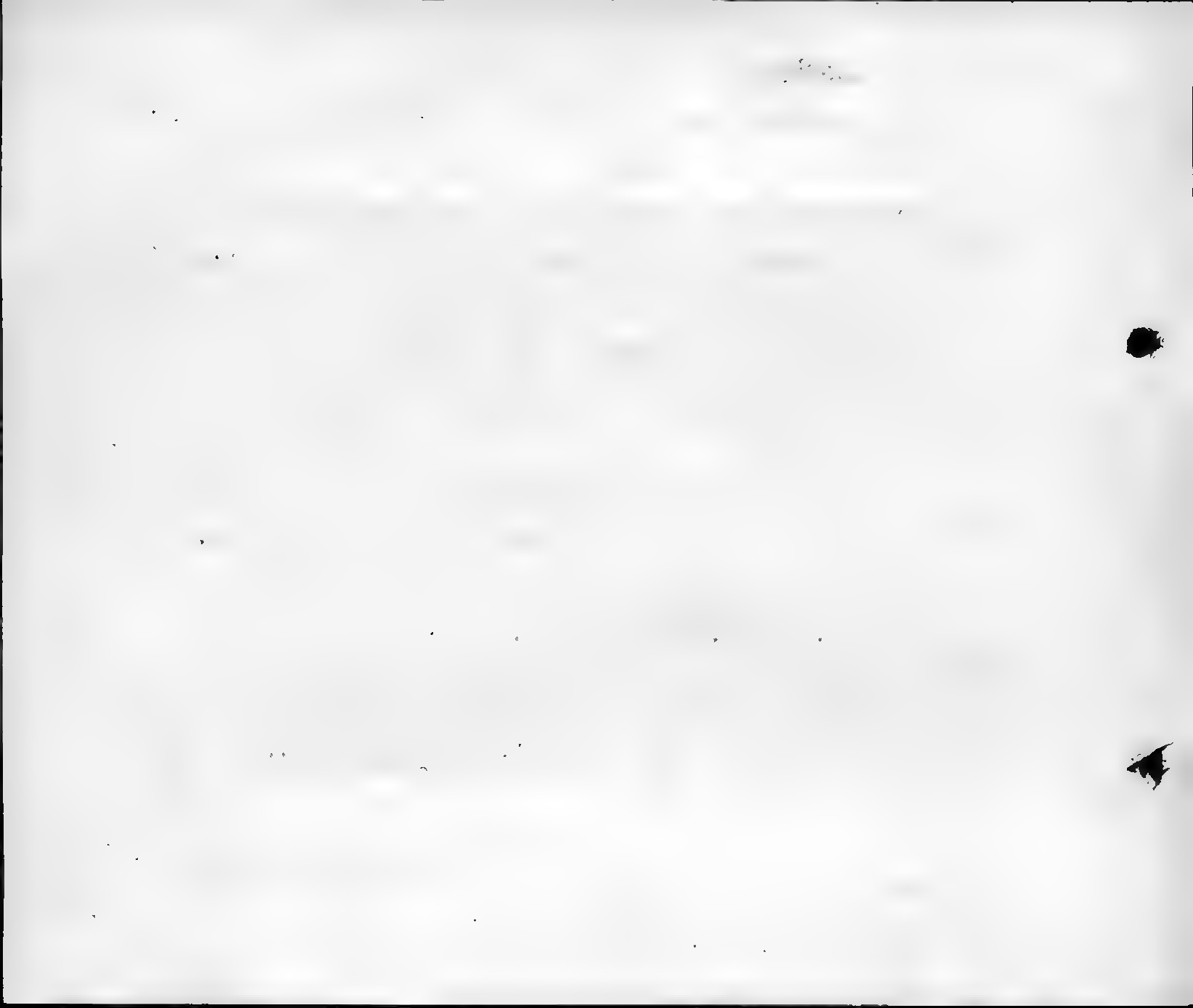
VR A1S (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2206

02184

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>6 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>702 Laurel Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Blaisdell</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/19/70</b>	9. AGE (in years last birthday) <b>90</b> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Crook</b>				14. MOTHER'S MAIDEN NAME <b>Emily V. Forsyth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Wm. W. Blaisdell-Cheverly, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism</b> <b>704.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture of Left Hip secondary to fall at home.</b> DUE TO (c) <b>5 days</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Congestive Ht. Failure, Mitral Stenosis, Coronary Heart Disease</b>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb., 11</b> 19 <b>61</b> to <b>Feb., 16</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb 16</b> 19 <b>61</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Manners Dunt C...</b> M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <b>2/16/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Prince Georges Hosp. Cheverly, Md.</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-19-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount View Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>West Friendship, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Haight</b> <b>Hydenville, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 23 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>	



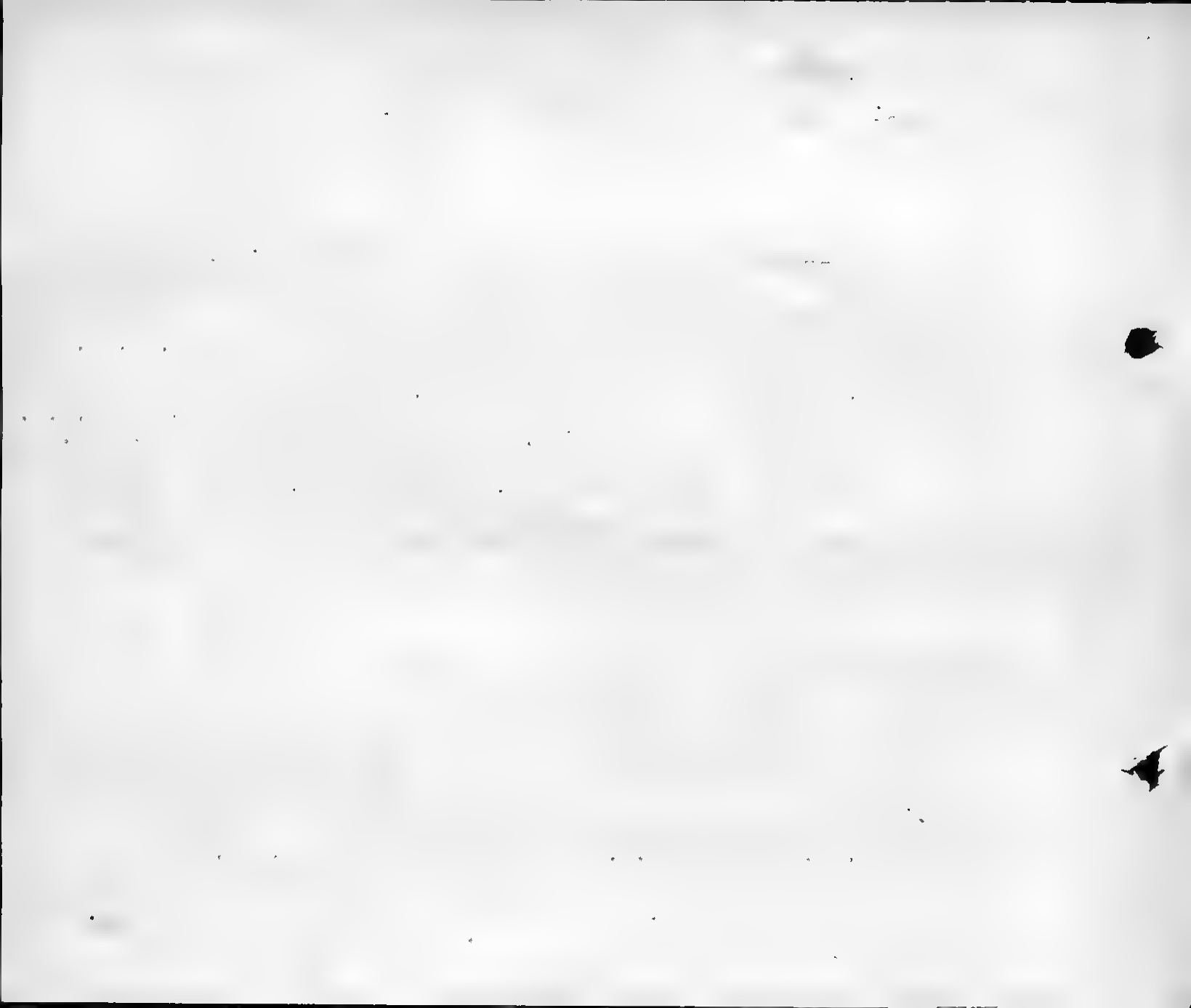


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2207 CERTIFICATE OF DEATH 02185

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 05 Mitchellville			
				d. STREET ADDRESS Box 58 Central Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First Middle Last Susan Myrtle Brady				4. DATE OF DEATH Month Day Year February 2 1961			
5 SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 6/7/75	
9 AGE (In years lost birthday) 85 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME George W. Higgs				14. MOTHER'S MAIDEN NAME Mary E. Mattingly			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16 SOCIAL SECURITY NO.		17. INFORMANT Address Washington, D.C. Mrs. Altie Zecca-1711 Mass. Ave., N.W.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Vascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 wk 8 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from 1 week 1960 to 2 Feb 1961, that (I) (we) last saw the deceased alive on 2 Feb 1961, and that death occurred at 1:08 from the causes and on the date stated above							
22a SIGNATURE R. B. Sasscer				M. D. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/2/61	
22c. PHYSICIAN'S NAME (Type) R. B. Sasscer, M.D.				22d. ADDRESS Upper Marlboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/6/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City, town or county) (State) Upper Marlboro, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ritchie Bros. Fun'l Home - Upper Marlboro;				25a. REC'D BY REGISTRAR DATE FEB 14 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

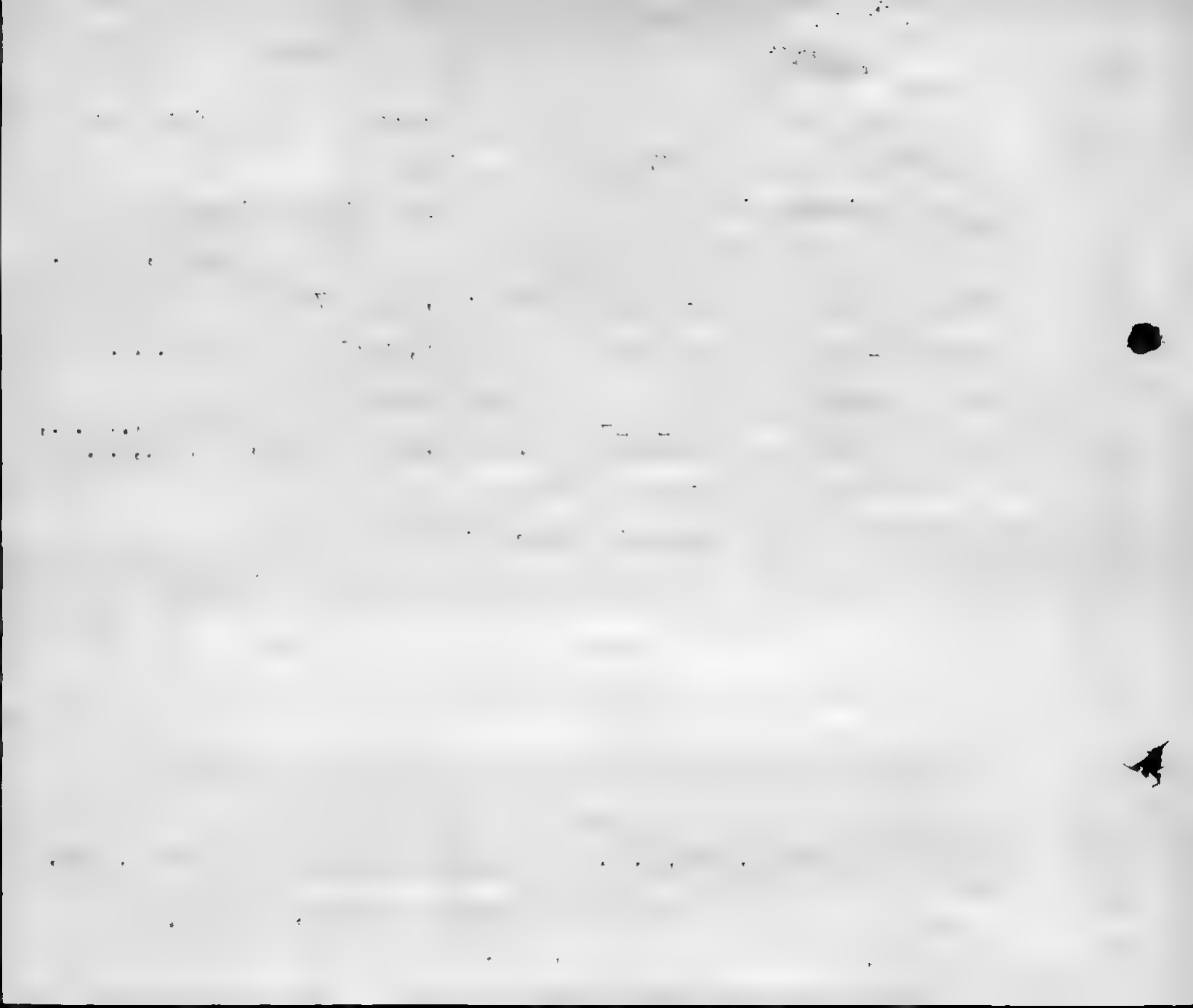


1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02186									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> c. LENGTH OF STAY in lb <b>47 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>11714 Ellington Drive</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>11714 Ellington Drive</b>				
3. NAME OF DECEASED (Type or print) <b>MARIE LOUISE BREWER</b>					4. DATE OF DEATH <b>February 7, 1961.</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>Negro</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>October 28, 1884</b>				
9. AGE (In years last birthday) <b>76</b> yrs.					10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours M. n.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife - Retired</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>				
11. BIRTHPLACE (State or foreign country) <b>Murkurk, Maryland</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Charles Briggs</b>					14. MOTHER'S MAIDEN NAME <b>Betty Harrison</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No None</b>					16. SOCIAL SECURITY NO. <b>218-38-7311</b>				
17. INFORMANT <b>Mrs. Anna E. Brewer Johnson,</b>					Address <b>518 F St., N.E., Wash., D.C.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 420. DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Myocardial Infraction</b> (a), stating the underlying cause last. (c) <b>Coronary Arteriosclerosis Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M. D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					Address (Street, city, town, or county) <b>February 7, 1961.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-11-61</b>					22b. DATE THEREOF <b>Queens Chapel Cemetery</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Murkurk, Maryland</b>					22d. LOCATION (City, town, or country) (State)				
23. FUNERAL DIRECTOR <b>HENRY S. WASHINGTON &amp; SONS NE, Wash. DC</b>					ADDRESS <b>4925 Dean Ave</b>				
					14a. REC'D BY REGISTRAR <b>FEB 10 '61</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>				



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

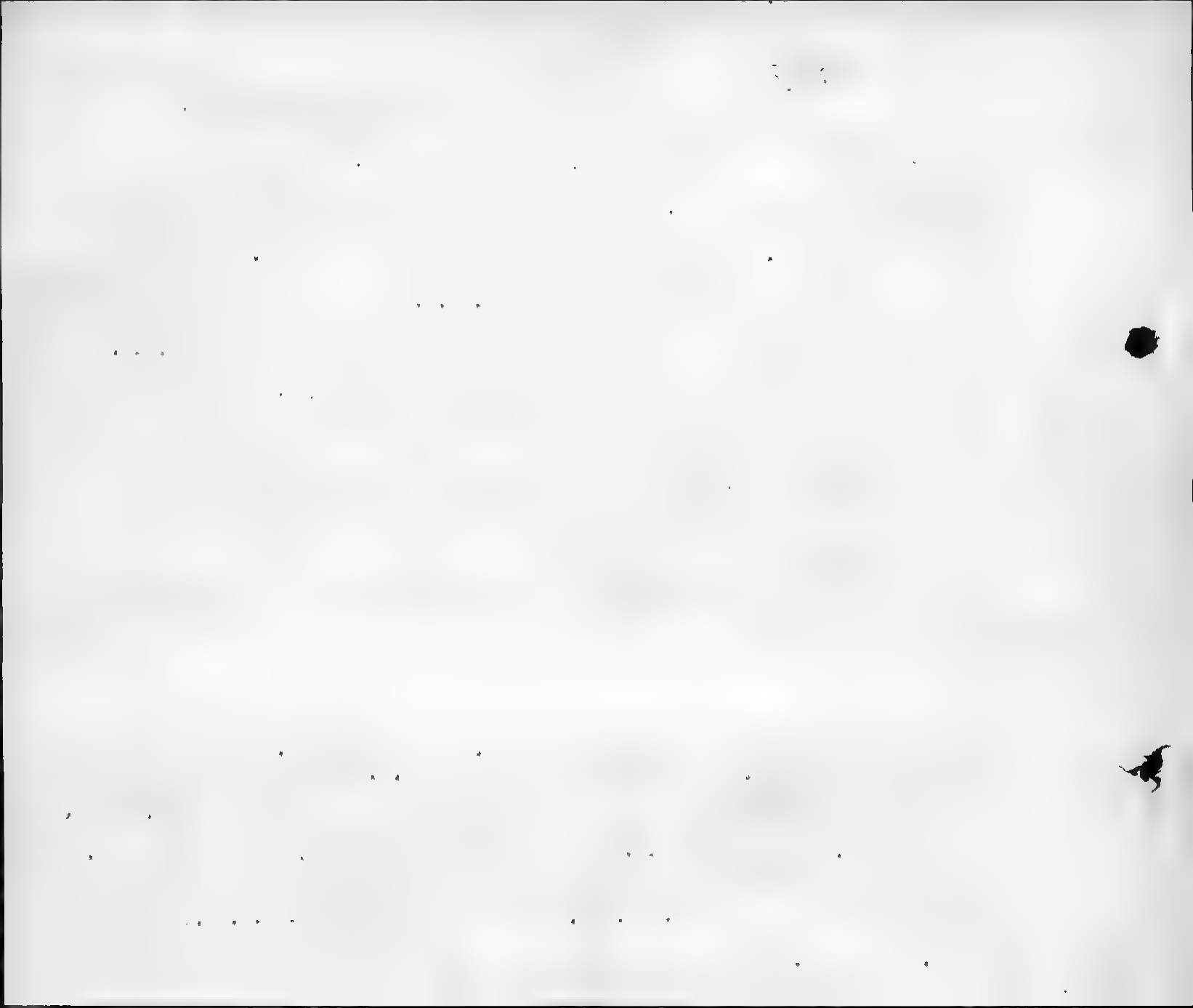
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2209

CERTIFICATE OF DEATH

0216

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>17 9 Weeks 3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland Park</b>			
d. STREET ADDRESS <b>1202 69th Place</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy A.</b> First Middle Last <b>Britt</b>				4. DATE OF DEATH <b>Feb. 10 19 61</b> Month Day Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 5. 1960</b>	
9. AGE (In years last birthday) <b>2</b> yrs.		IF UNDER 1 YEAR <b>2</b> Months <b>16</b> Days		IF UNDER 24 HRS <b>16</b> Hours <b>16</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Leon Britt</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Mc Clurkin</b>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>None</b>		17 INFORMANT <b>Mother</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Massive White SubDural Hematoma And Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Dec. 5 1961</b> to <b>Feb. 10 1961</b> , that (I) (we) last saw the deceased alive on <b>Dec. 9 1961</b> , and that death occurred at <b>2 A.M.</b> from the causes and on the date stated above							
22a SIGNATURE <b>Dr. John Perkins M.D.</b>				22b. ADDRESS <b>5301 Hamilton St., Hyattsville, Md.</b>			
22c PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b DATE THEREOF <b>2/17/61</b>		23c NAME OF CEMETERY OR CREMATORY <b>Pr. Geo. Gen. Hospital</b>		23d LOCATION (City, town, or county) (State) <b>Cheverly, P.G.Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Adm.</b>				25a REC'D BY REGISTRAR <b>Feb 21 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Caroline S. House</b>			

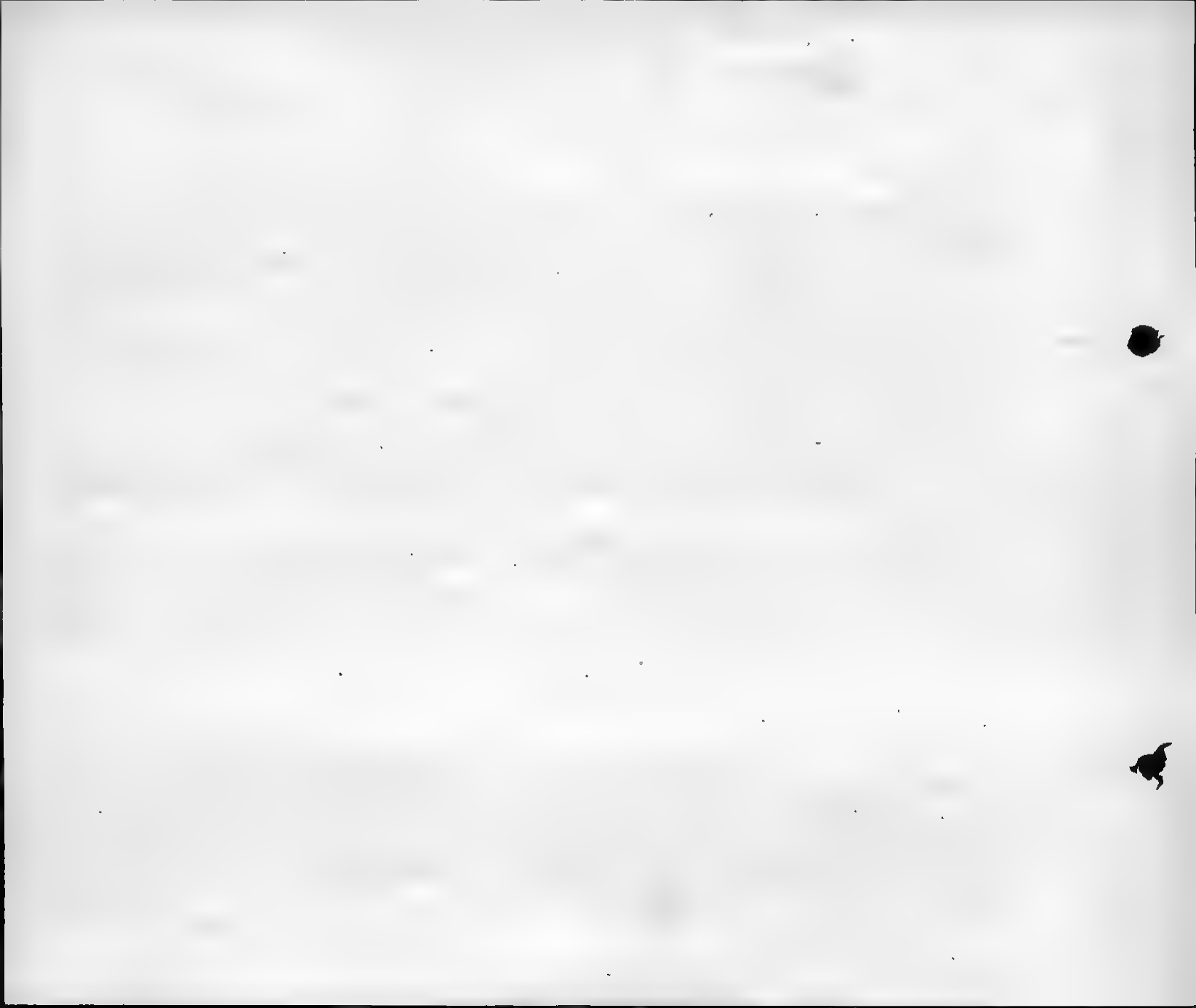




1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02188

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN lb <b>8 HOURS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL, WASH 25, DC</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b> c. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <b>INDIANHEAD</b> d. STREET ADDRESS <b>BOQ, US NAVAL PROPELLANT PLANT</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W</b> Last <b>BROADBENT</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>17</b> Year <b>19 61</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 AUGUST 1935</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US NAVAL OFFICER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US NAVY</b>	9. AGE (In years last birthday) <b>25</b> yrs
11. BIRTHPLACE (State or foreign country) <b>MASSACHUSETTS</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>DONALD BROADBENT</b>		14. MOTHER'S MAIDEN NAME <b>BARBARA M ZAUGG</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>1957 - 1961 031-266-3346</b>	
17. INFORMANT <b>PERSONNEL AND HOSPITAL CHARTS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE FRACTURES, LEFT FEMUR &amp; TIBIA, RIGHT RADIUS &amp; ULNA</b> DUE TO <b>CRANIAL CEREBRAL INJURY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>MULTIPLE LACERATIONS, LEFT AXILLA &amp; RIGHT LEG</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 HOURS</b> <b>8 HOURS</b> <b>8 HOURS</b>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INVOLVED IN 3 CAR COLLISION ON RT #210, GLYMONT, MD</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>INVOLVED IN 3 CAR COLLISION ON RT #210, GLYMONT, MD</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:45</b> p.m. <b>Feb 16 1961</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>MD ROUTE 210</b>	20f. (City or town) (County) (State) <b>GLYMONT CHARLES MD</b>
21. I certify that (I) <del>this hospital</del> attended the deceased from <b>17 FEBRUARY 19 61</b> to <b>17 FEBRUARY 19 61</b> . that (I) <del>(the)</del> last saw the deceased alive on <b>17 FEBRUARY 19 61</b> , and that death occurred at <b>9:45 A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John A. Hennesen Jr.</b>		22b. DATE SIGNED <b>17 FEBRUARY 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A HENNESSEN JR, LT COL USAF MC</b>		22d. ADDRESS <b>USAF HOSP, ANDREWS AFB, WASH 25, DC</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2/21/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BIRCHWOOD CEMETERY CENTERVILLE MASS.</b>	23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Inc.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 23 '61</b>	
ADDRESS <b>1400 Chapin St NW WASHINGTON, DC</b>		25b. REGISTRAR'S SIGNATURE <b>C. H. S. Hines</b>	



FOR STATE  
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

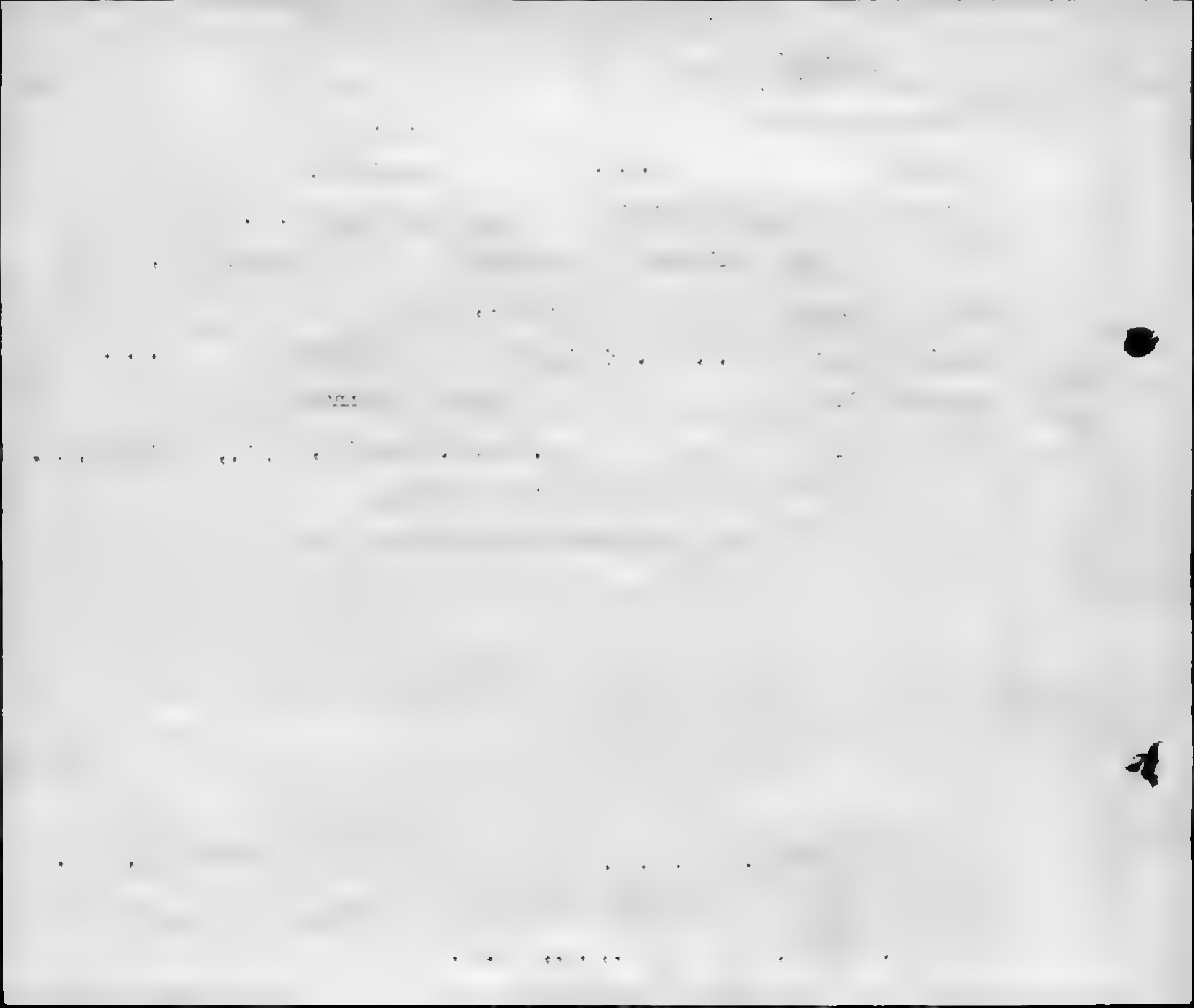
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 221 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02183

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b>		b. COUNTY <b>None</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>4620 Iowa Avenue N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		3. NAME OF DECEASED (Type or print) <b>JAMES WOODMAN BRODERICK</b>		4. DATE OF DEATH <b>February 18, 19 61</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 2, 1900</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS <b>60</b> yrs. Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Planning Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT. Printing</b>		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Broderick</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Cavanaugh</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Mabel I. Broderick</b>		Address <b>4620 Iowa Avenue N. W., Washington, D.C.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Coronary Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Washington</b>		(County) <b>D.C.</b>		(State) <b>D.C.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>James I. Boyd</b>		EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>February 19, 1961.</b>		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>		22d. LOCATION (City, town, or country) <b>Arlington Va.</b>		22e. REC'D BY REG. STRAR <b>Francis J. Collins</b>		24b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>		24c. FEB 21 '61		24d. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

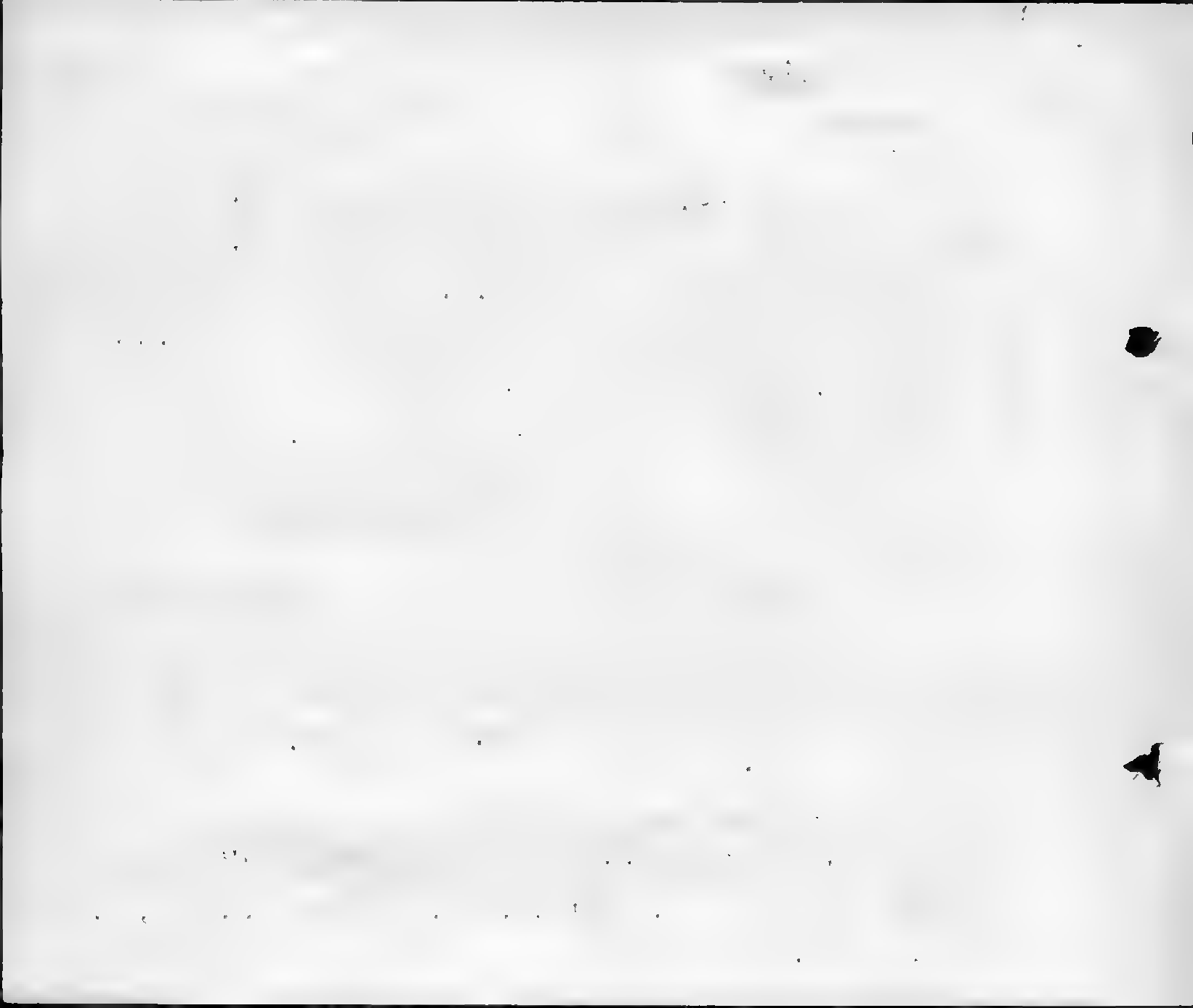


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;"><b>2212</b></span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>3022 Kennilworth Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Baby girl</b> <span style="float: right;">First Middle Last</span> <b>Female</b> <span style="float: right;"><b>Colored</b></span> <b>6. COLOR OR RACE</b> <b>Colored</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>4. DATE OF DEATH</b> <b>Feb. 7 1961</b> <b>5. DATE OF BIRTH</b> <b>Feb. 7. 1961</b> <b>9. AGE</b> (In years last birthday) <b>2</b> yrs <b>10</b> months <b>10</b> days <b>10. USUAL OCCUPATION</b> (Give kind of work done during part of working life, even if retired) <b>None</b> <b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Donald J. Brown</b> <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>None</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Josephine Barnes</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Mother</b> <b>Mrs Josephine Brown.</b> <span style="float: right;">Address <b>Same</b></span>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>762.5 atelectasis</b> DUE TO (b) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year <b>Feb. 7 1961</b> Hour o. m. p. m. <b>2:10 PM</b> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb. 7 1961</b> <b>to</b> <b>Feb. 7 1961</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Feb. 7 1961</b> <b>and that death occurred at</b> <b>2:10 PM</b> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>John W. Perkins</i> <span style="float: right;">M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></span> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Dr. John Perkins, M.D.</b> <span style="float: right;">22b. ADDRESS <b>5301 Hamilton St., Hyattsville, Md.</b></span>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b> <b>23b. DATE THEREOF</b> <b>2/28/61</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Pr. George's Gen. Hospt.</b> <b>23d. LOCATION (City, town, or county)</b> <b>Cheverly, P.G. County, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HARRY W. PENN, ADM.</b> <span style="float: right;">25a. REC'D BY REGISTRAR <b>MAR 7 '61</b></span> <span style="float: right;">25b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i></span>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 101

2213

## 1. PLACE OF DEATH

a. COUNTY

Prince Georges

MARYLAND

## 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)

a. STATE

b. COUNTY

District of Columbia

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Adelphi

c. LENGTH OF STAY IN 1b

2 yrs. 1 mo

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Washington

47X

d. NAME OF HOSPITAL (If not in hospital, give street, address) OR INSTITUTION

Faint Branch Nursing Home

d. STREET ADDRESS

1607 Eastern Ave

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

## 3. NAME OF DECEASED

(Type or print)

Berse

First

Brinton

Last

Brown

## 4. DATE OF DEATH

Month

Feb.

Day

Year

8 1961

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

## 8. DATE OF BIRTH

Mar. 20, 1917

## 9. AGE (In years last birthday)

72 yrs.

## 10. IF UNDER 1 YEAR

Months Days Hours Min.

## 11. IF UNDER 24 HRS

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard Duty

10b. KIND OF BUSINESS OR INDUSTRY

St. Elizabeths Hosp

11. BIRTHPLACE (State or foreign country)

Broad top, Penn.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Joseph. Brown

## 14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

No

16. SOCIAL SECURITY NO.

None

## INFORMANT

Nursing Home Records.

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

331X

DUE TO

Cerebral Vascular Accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO

Hypertension

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 Days

Several years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 1-8, 1962, to 2-8, 1961, that I last saw the deceased alive on 2-6, 1961, and that death occurred at 7:25 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE

Stuart L. Nelson

M.D.

ADDRESS (Street, city or town, state)

7600 Carroll Ave. Takoma Park, Md. 2-8-61

DATE SIGNED

PHYSICIAN'S NAME (Type)

STUART L. Nelson M.D.

22a. RURAL CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

2-9-61

22c. NAME OF CEMETERY OR CREMATORY

W. of Md. Med. School

22d. LOCATION (City, town, or county)

Baltimore, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D BY REGISTRAR

DATE FEB 10 '61

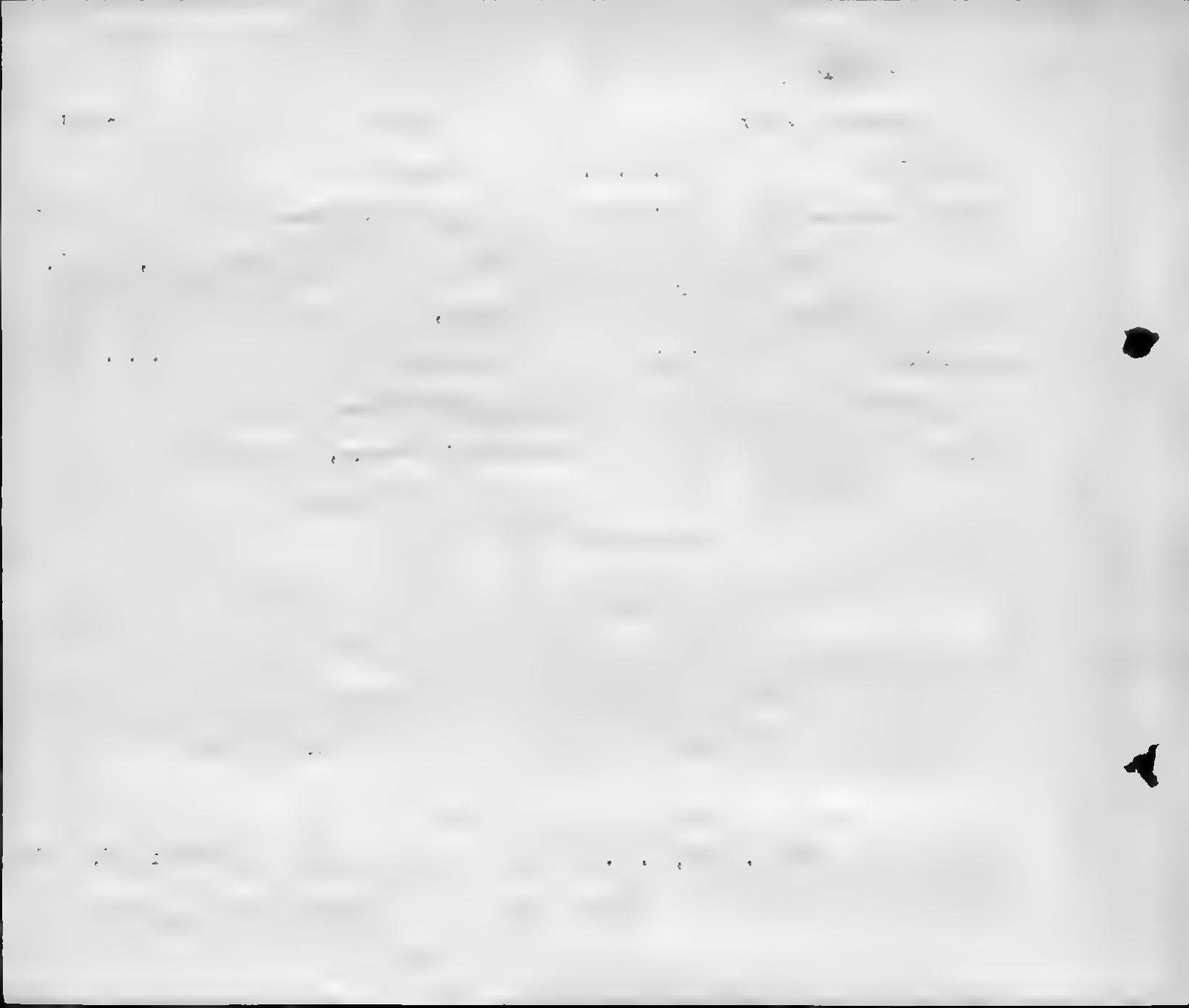
24b. REGISTRAR'S SIGNATURE

Arthur S. Hanna

72  
The following is a list of the  
names of the persons who  
were present at the meeting  
of the Board of Directors  
of the Company held on  
the 12th day of May, 1902.







may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2218

2218

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02196

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> 74	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Lanham General Hospital</u>		d. STREET ADDRESS <u>3910 Lanham Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie L. Cook</u> First Middle Last		4. DATE OF DEATH <u>February 11 1961</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31 1873</u> 87 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Lucas</u>		14. MOTHER'S MAIDEN NAME <u>Helia Elizabeth Whittle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Nellie Fairall, Beltsville, Md</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cordiac Dehiscence</u> 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>1 1/2</u> <u>20</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1230</u> to <u>2/11</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>2/10</u> 19 <u>61</u> , and that death occurred at <u>150M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>B.P. Warren</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>B.P. WARREN</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/13/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Calmar Manor Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>DeWitt Davidson, Lanham Md</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 20 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

M

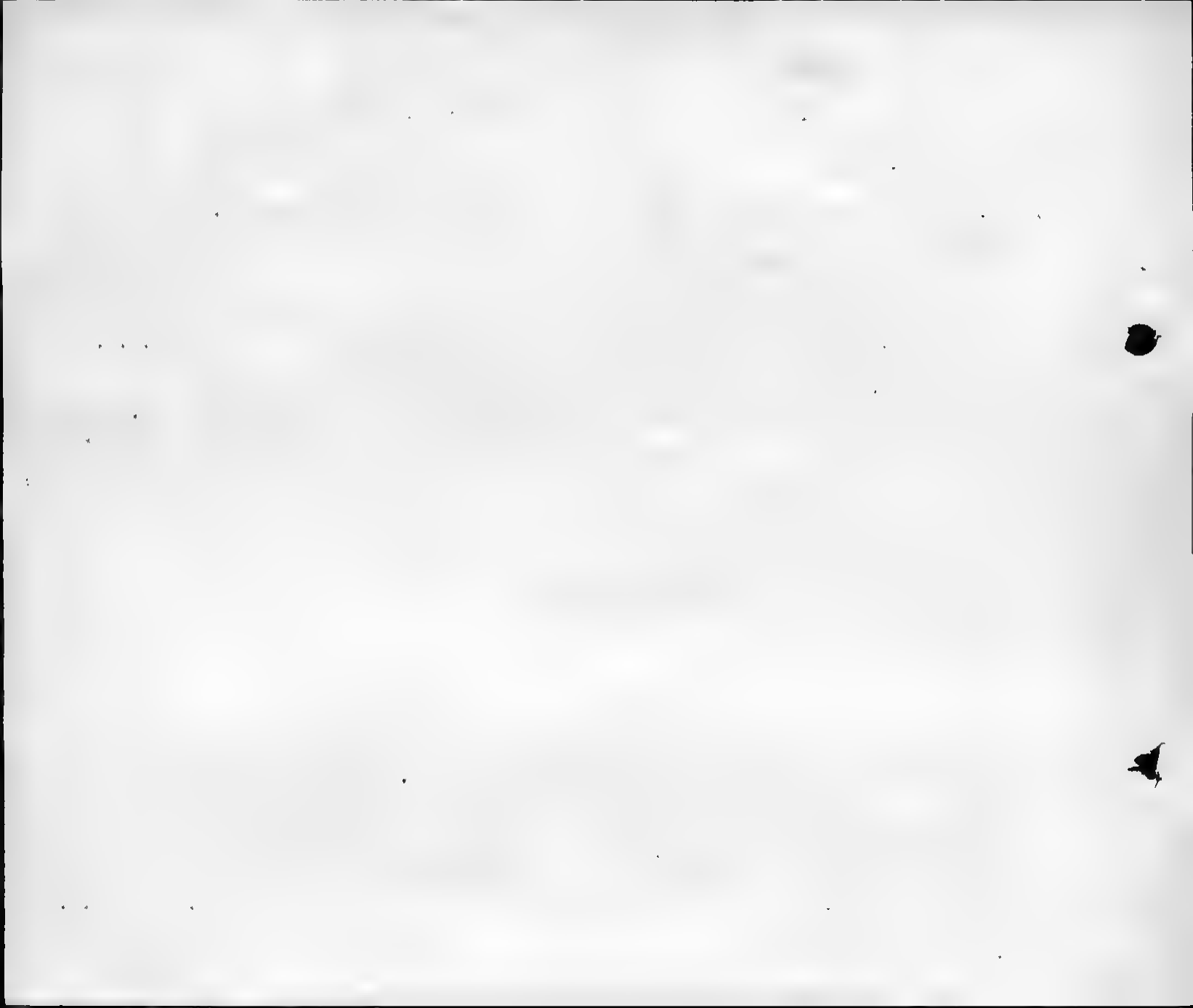
I



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2215  
CERTIFICATE OF DEATH  
02193

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut on. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Nathan</b> Middle <b>Cannon</b> Last <b>Cannon</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>6</b> Year <b>19 61</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>82</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Painter</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Cannon</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>No</b>		17. INFORMANT <b>Sadie Schnapp</b> Address <b>1104 Raydale Rd Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <b>THROMBOSIS, RT MID CEREBRAL ARTERY</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>JAN 1 1958</b> to <b>FEB 6 1961</b> , that (I) (the hospital) saw the deceased alive on <b>FEB 6 1961</b> , and that death occurred at <b>1.00AM</b> on the causes and on the date stated above							
22a. SIGNATURE <b>Samuel J. N. Sugar</b>				22b. ADDRESS <b>MT. RAINIER, Md.</b>		22c. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-8-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Montefiore Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Springfield L.I., N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 8 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



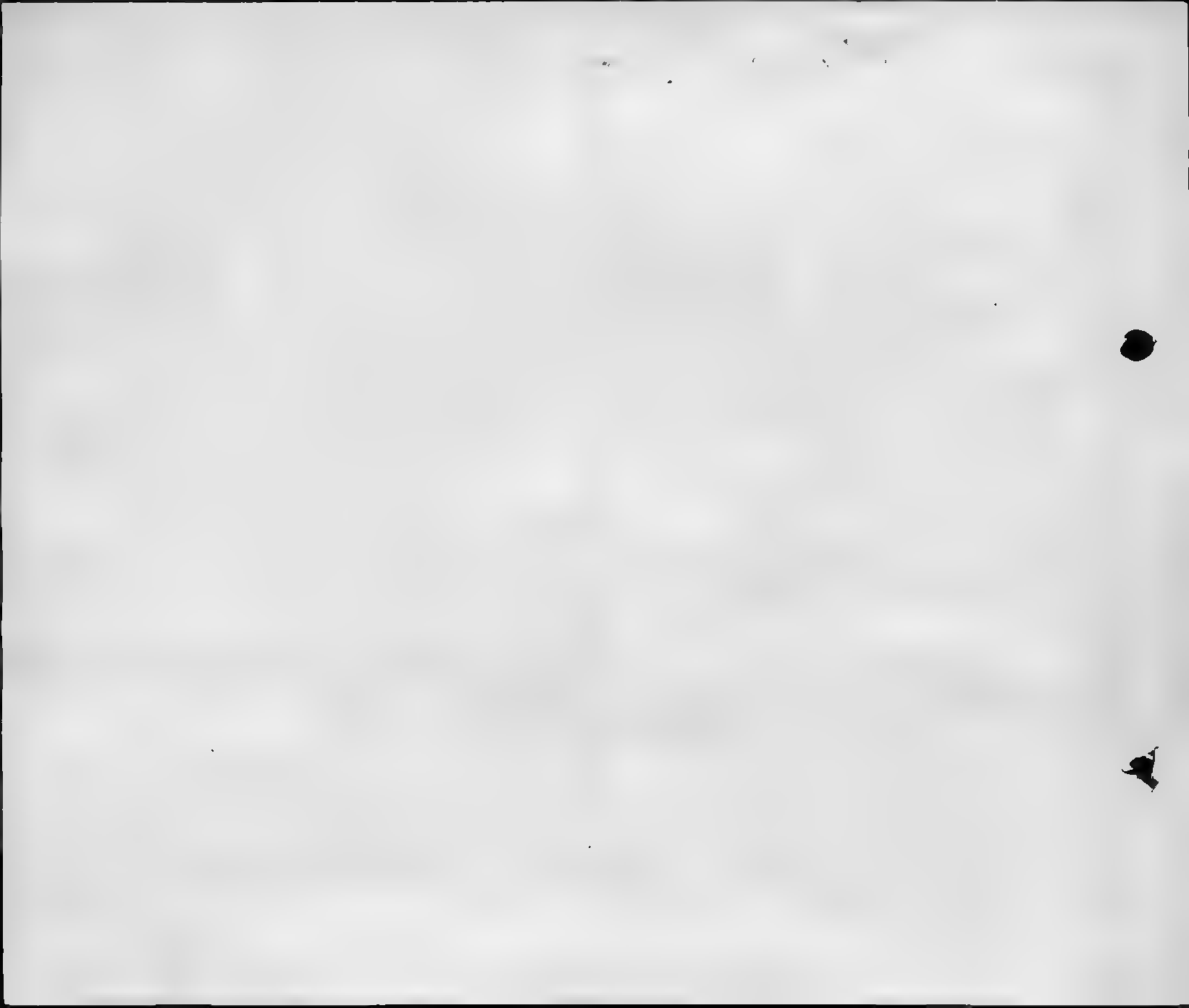
# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2217 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> c. LENGTH OF STAY IN 1b <u>4 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13 Summer Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Res. given before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> d. STREET ADDRESS <u>13 Summer Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Theresa Anna Coffman</u> 1st Last <b>4. DATE OF DEATH</b> <u>Feb 14 1961</u> Month Day Year		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Oct 17, 1960</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>District of Columbia, D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Eldon Coffman</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Riggs</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>none</u> <b>17. INFORMANT</b> <u>Mrs. Ida Coffman, same as #2</u> Address _____		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> <u>493X</u> <b>DUE TO</b> <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>DUE TO</b> _____ <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a.</b> _____	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURRED</b> <u>While at work</u> <input type="checkbox"/> <b>Not While at work</b> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASS STANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>Feb 14, 1961</u> Address (Street, city, town, or county) _____			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>2-16-61</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Natl.</u> <b>22d. LOCATION (city, town, or county)</b> <u>Arlington Natl.</u> (State) _____		<b>23. FUNERAL DIRECTOR</b> <u>Simmons Bros.</u> <b>ADDRESS</b> <u>1661-6000 Hope Rd SE WASH 20 DC</u> <b>24a. REC'D BY REGISTRAR</b> <u>DA FEB 15 '61</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Harris</u>	

VS. A19ME  
SM 1139

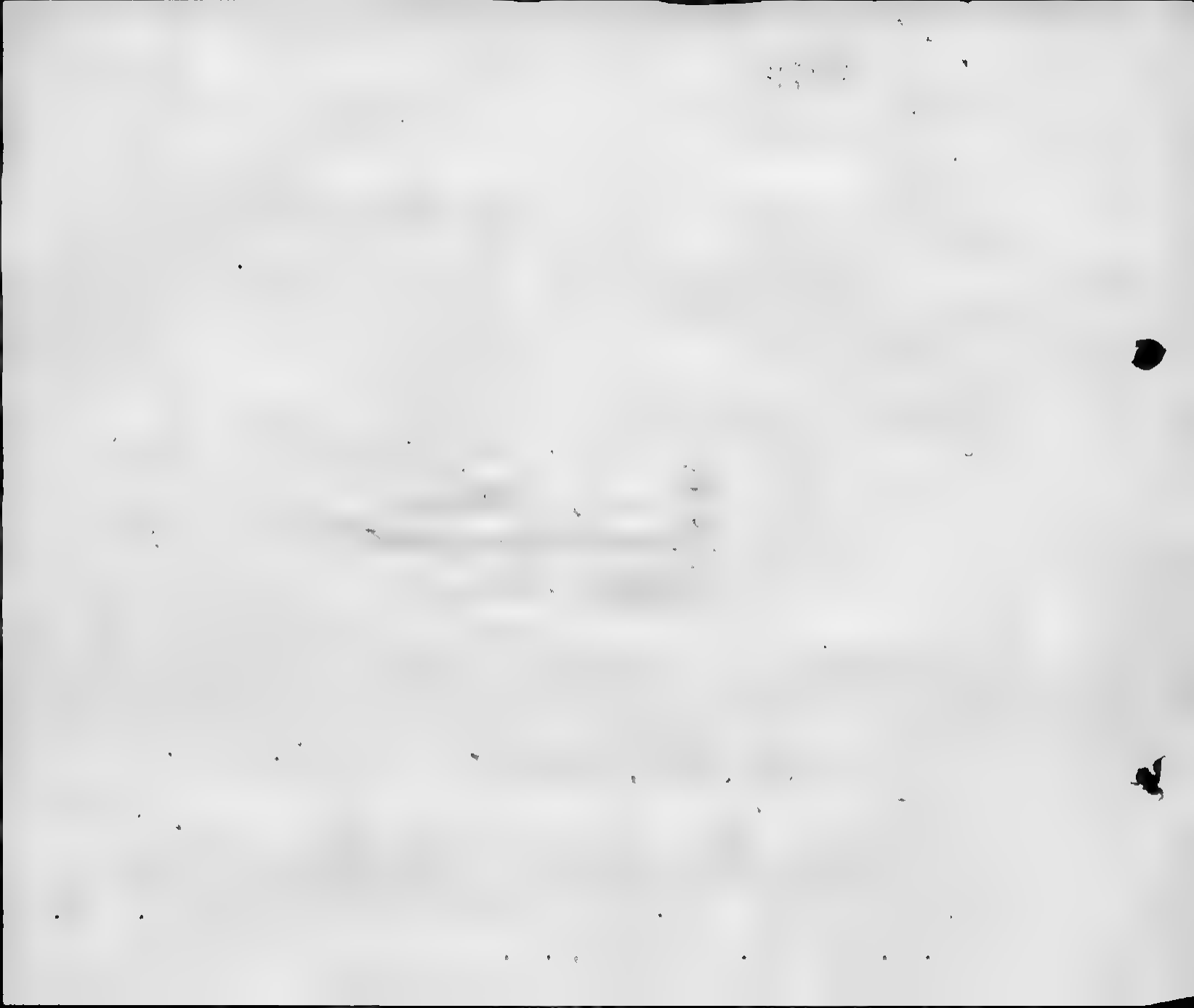




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																							
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																							
CERTIFICATE OF DEATH																							
2219																							
0219																							
1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> c. LENGTH OF STAY IN b <b>unknown</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4702 Huron Avenue</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Suitland</b> d. STREET ADDRESS <b>4702 Huron Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Agatha</b>				4. DATE OF DEATH <b>Feb. 2 1961</b>				5. SEX <b>female</b>															
6. COLOR OR RACE <b>white</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2/25/1883</b>															
9. AGE (in years last birthday) <b>77</b> yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Italy</b>															
12. CITIZEN OF WHAT COUNTRY <b>USA</b>				13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Joseph Cosimano (same as above)</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crowning reduction</b> <b>420.1</b> DUE TO <b>Chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Arteriosclerosis</b> DUE TO <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)											
20c. TIME OF INJURY Hour <b>a.m.</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <b>12-22-1960</b> to <b>Feb. 1, 1961</b> , that (I) (we) last saw the deceased alive on <b>Jan. 31, 1961</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above.																							
22a. SIGNATURE <b>Eugene A. Forcione, M.D.</b>				22b. DATE SIGNED <b>Feb 2, 1961</b>				22c. PHYSICIAN'S NAME (Type) <b>EUGENE A. FORCIONE</b>				22d. ADDRESS <b>2100 Conn. Ave. N.W.</b>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2/6/61</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Prince Georges Co. Md.</b>											
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. Washington, D. C.</b>				25a. REC'D BY REGISTRAR <b>FEB 3 '61</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				25c. DATE <b>FEB 3 '61</b>											



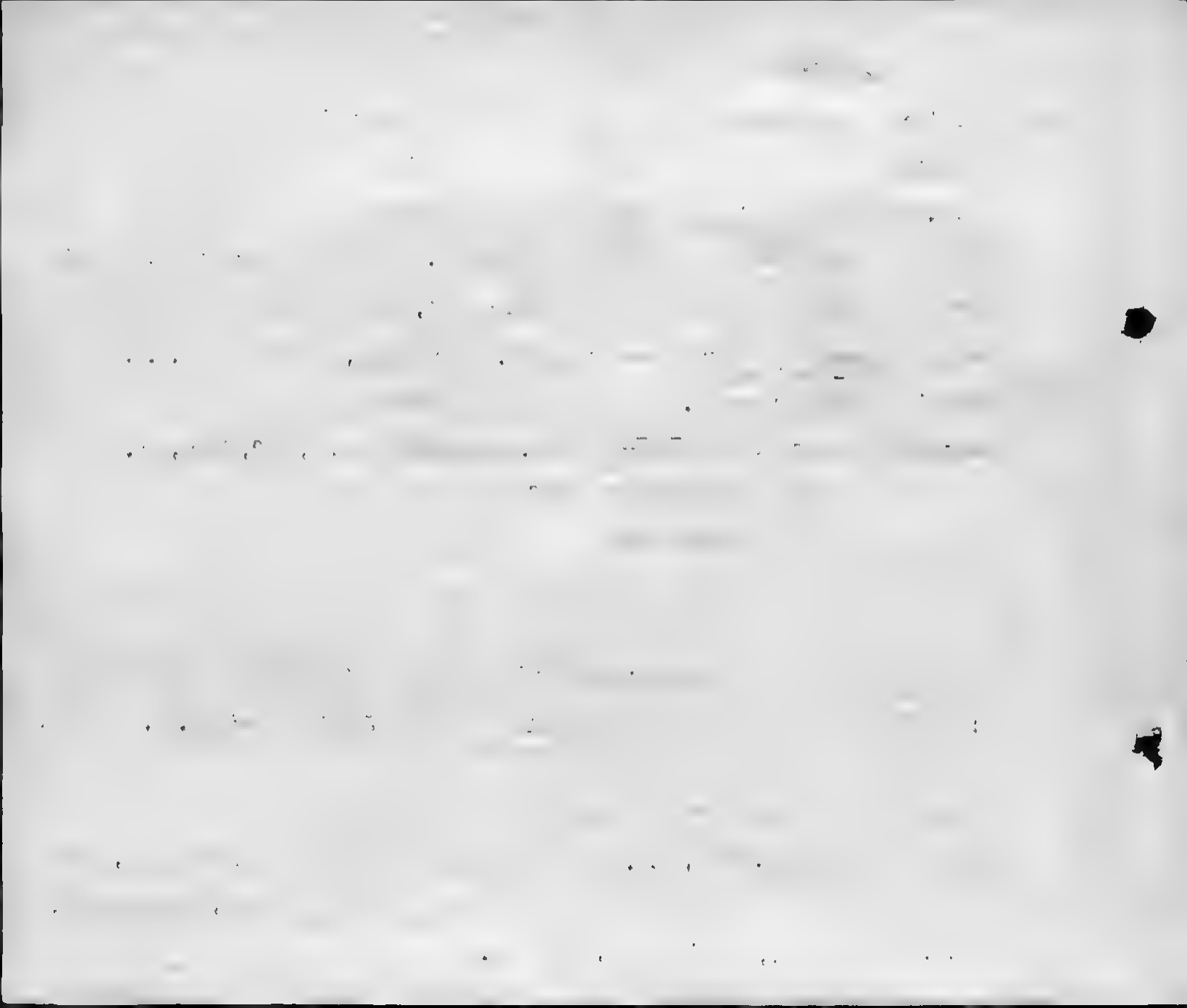
1/8  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2220 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02198											
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> c. LENGTH OF STAY IN 1b <b>Pa. RR Spur to Bowie Race Track</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>York</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>York</b> d. STREET ADDRESS <b>RD 2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>FREDERICK</b>		First <b>WORMAN</b>		Middle <b>CRAMER JR.</b>		Last <b>CRAMER JR.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2,</b> Year <b>19 61</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 23, 1912</b>		9. AGE (in years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>x</b>		11. IF UNDER 24 HRS. Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Operator</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>York Stone Supply Co.</b>			11. BIRTHPLACE (State or foreign country) <b>Frederick, Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>											
13. FATHER'S NAME <b>Frederick Worman Cramer Sr.</b>						14. MOTHER'S MAIDEN NAME <b>Nina Marshall</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Unknown No</b>						16. SOCIAL SECURITY NO. <b>187-24-0382</b>					
17. INFORMANT <b>Mrs. Dorothy May Cramer, RD2, York, Pa.</b>						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO (b) <b>Crushed skull</b> DUE TO (c) <b>Crushed skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger of a train that was in a wreck</b>							
20c. TIME OF INJURY Month, Day, Year <b>1:00 p.m. 2/2 19 61</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Train</b>			
20f. (City or town) <b>Jerricho Park</b>				20g. (County) <b>P. G.</b>				20h. (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>James I. Boyd</b>				EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>				DATE SIGNED <b>February 2, 1961</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>FEB 6, 1961</b>				22c. NAME OF CEMETERY OR CREMATORY <b>W.W. CHAMBERS CO., Riverdale, Maryland.</b>			
22d. LOCATION (City, town, or county) <b>York, Pennsylvania.</b>				22e. REC'D BY REGISTRAR <b>FEB 8 '61</b>				22f. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			

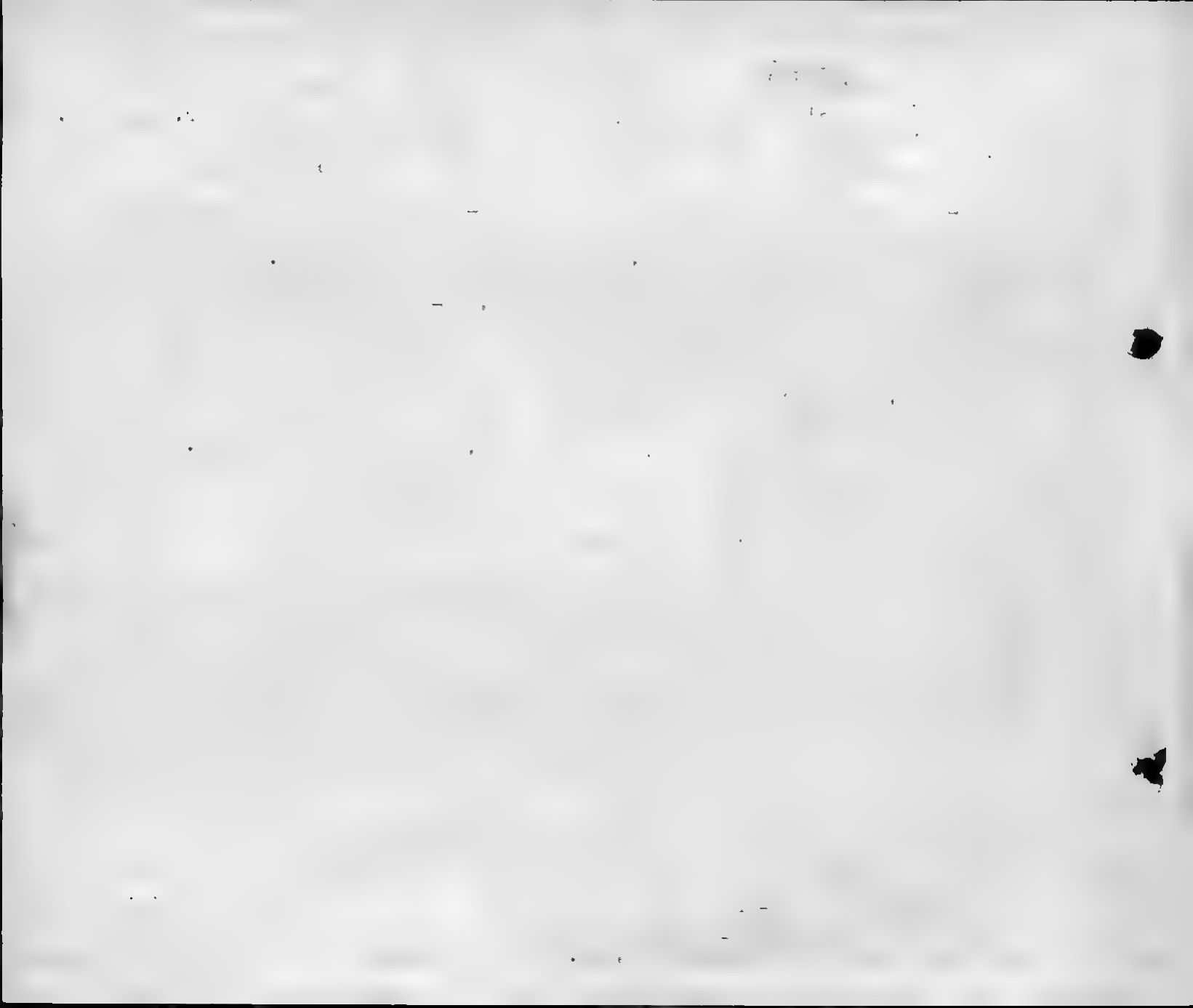


TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
2216 02199											
1. PLACE OF DEATH a. COUNTY Prince George's				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights				c. LENGTH OF STAY in lb 3 Months				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) District Heights, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7118- District Heights Parkway				d. STREET ADDRESS 7118- District Heights Parkway				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle F. Last ORISTY				4. DATE OF DEATH Feb. 27th 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 23- 1888		9. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Domestic				11. BIRTHPLACE (County & State, or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert O. Mc Olvin				14. MOTHER'S MAIDEN NAME Mary Pickering							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NO				17. INFORMANT Nelson G. Cristy Same as # 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-20-61 DUE TO (b) Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) (b) Hypertensive arteriosclerotic Coronary H.D. 5-6 yrs. DUE TO (c) Coronary Occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) Diabobates Mellitus				INTERVAL BETWEEN ONSET AND DEATH 3-4 Days 7-8 Days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Nov. 1960 to 27 Feb. 1961		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 1960 to 27 Feb. 1961, that (I) (we) last saw the deceased alive on Feb. 26, 1961, and that death occurred at 10 PM, from the causes and on the date stated above.											
22a. SIGNATURE Sidney W. Lowry M.D.				22b. DATE SIGNED 2/27/61							
22c. PHYSICIAN'S NAME (Type) SIDNEY W. LOWRY M.D.				22d. ADDRESS 7200- MARLBORO PIKE SE.							
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial March 2-61				23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION (City, town or county) Fairmont, West Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers				1661- Good Hope Road SE Washington 20, DC.				25a. REC'D BY REGISTRAR DATE MAR 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hous	



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forestville</b> d. STREET ADDRESS <b>4105 82nd Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Howard</b> First Middle Last		4. DATE OF DEATH <b>Feb. 24 1961</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/29/1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	9. AGE (In years last birthday) <b>76</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Richard Dalby</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If given, give war dates of service) <b>National Guard</b>	
17. INFORMANT <b>Ethel Dalby (wife)</b> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Hypertensive arteriosclerosis Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 weeks</b> <b>8-10 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 58</b> to <b>Feb. 24, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 24, 1961</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>S. W. Lowry</b> 22c. PHYSICIAN'S NAME (Type) <b>S. W. LOWRY, M.D.</b>		22b. DATE SIGNED <b>Feb. 24, 1961</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. ADDRESS <b>7200-MARLBORO PIKE S.E. WASH. DC.</b>			
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 27, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Nat'l &amp; Southland Md.</b>		23d. LOCATION (City, town, or county) (State) <b>Wash. D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee</b> ADDRESS <b>Wash. D. C.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. K...</b>			





## CERTIFICATE OF DEATH

Reg. Dist. No. 02201

2222

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>				c. LENGTH OF STAY IN 1b <b>SEVERN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL GENERAL Hospital</b>				d. STREET ADDRESS <b>Box 14, MINNIETORKA ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROY</b> Middle <b>WILLIAM</b> Last <b>DARNELL</b>				4. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/22/ 1900</b>	
9. AGE (In years last birthday) <b>60 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>molder helper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Naval Gun Factory</b>			
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>ESTELLE DARNELL, wife</b>				Address <b>SAME</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inflammatory Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cerebral &amp; General Arteriosclerosis</b> DUE TO (c) <b>Stasis Pneumonia</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>2-1</b> , 19 <b>61</b> , to <b>2-11</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>2-11</b> , 19 <b>61</b> , and that death occurred at <b>11:40 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Idolo Pierandrei</b>				ADDRESS (Street, city or town, state) <b>LAUREL, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>IDOLO PIERANDREI</b>				DATE SIGNED <b>2/11/61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2/14/61</b>		<b>Sanage Cemetery</b>		<b>Sanage Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Donaldson</b>				ADDRESS <b>Laurel Md</b>		24. REC'D BY REGISTRAR DATE <b>FEB 20 '61</b>	
				25. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

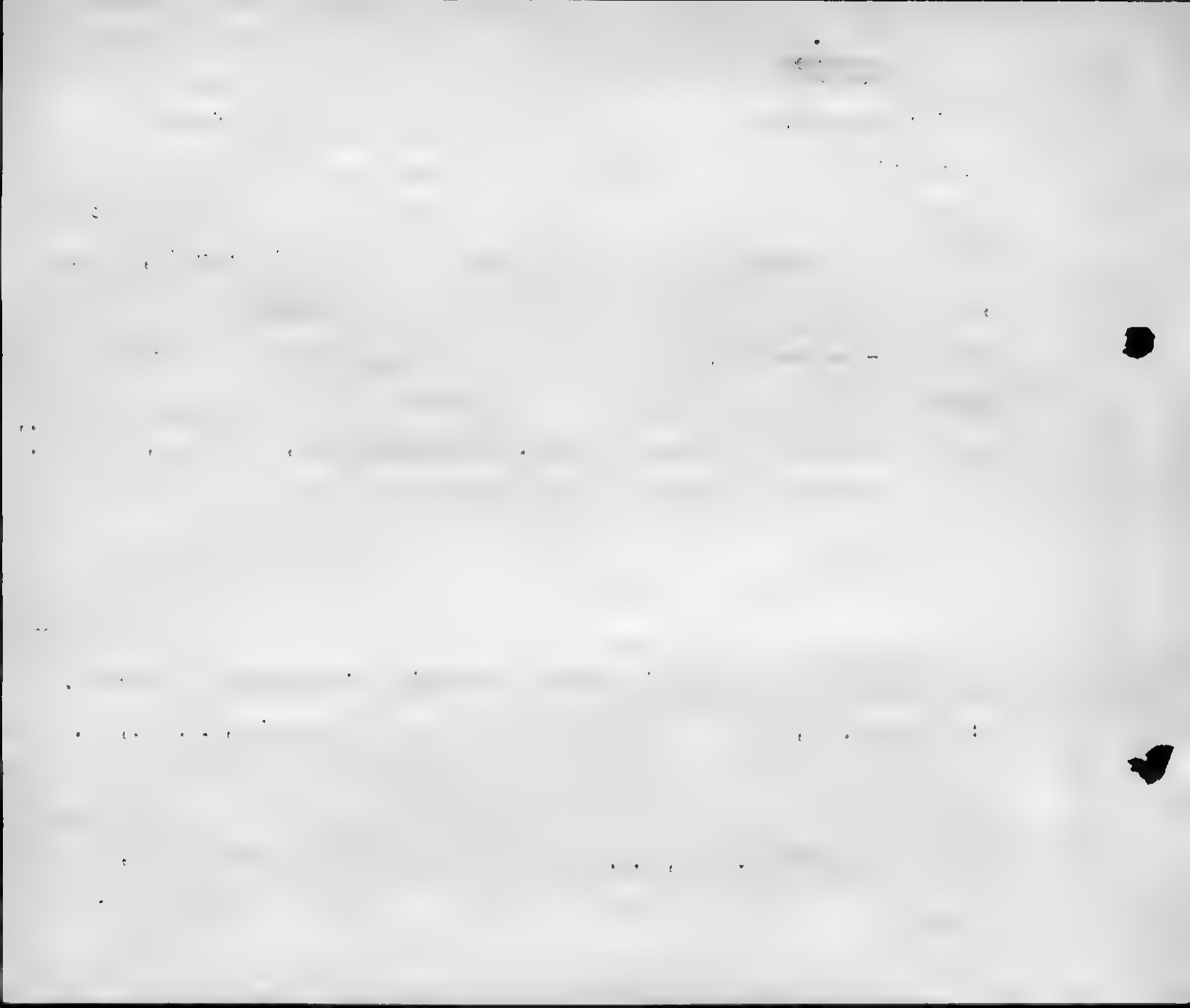


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
2223											
022-2											
1. PLACE OF DEATH											
a. COUNTY Prince Georges County											
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Brandywine											
c. LENGTH OF STAY IN 1b 4 Years											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rural											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. STATE Maryland											
b. COUNTY Prince Georges											
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Brandywine											
d. STREET ADDRESS Rural											
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ALLEN											
4. DATE OF DEATH February 11, 19 61											
5. SEX Male											
6. COLOR OR RACE White											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH February 22, 19 69											
9. AGE (In years last birthday) 22 69 yrs											
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist - Retired											
11. BIRTHPLACE (State or foreign country) Hungary											
12. CITIZEN OF WHAT COUNTRY? Unknown											
13. FATHER'S NAME Unknown											
14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown											
16. SOCIAL SECURITY NO. Unknown											
17. INFORMANT Mrs. Dorothy Stephenson, Address #6 Petercooper Rd., New York, New York.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Universal Charring burns of Body											
916.8 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Fire in house he was staying which burned to the ground.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 1:05 PM Feb. 11, 19 61											
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home											
20f. (City or town) Brandywine, P.G. Cty., Md.											
20g. (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd											
EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF 2-18-61											
22c. NAME OF CEMETERY OR CREMATORY Washington National											
22d. LOCATION (City, town, or country) Suitland Maryland											
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.											
24a. REC'D BY REGISTRAR DATE FEB 20 '61											
24b. REGISTRAR'S SIGNATURE Arthur L. Hume											

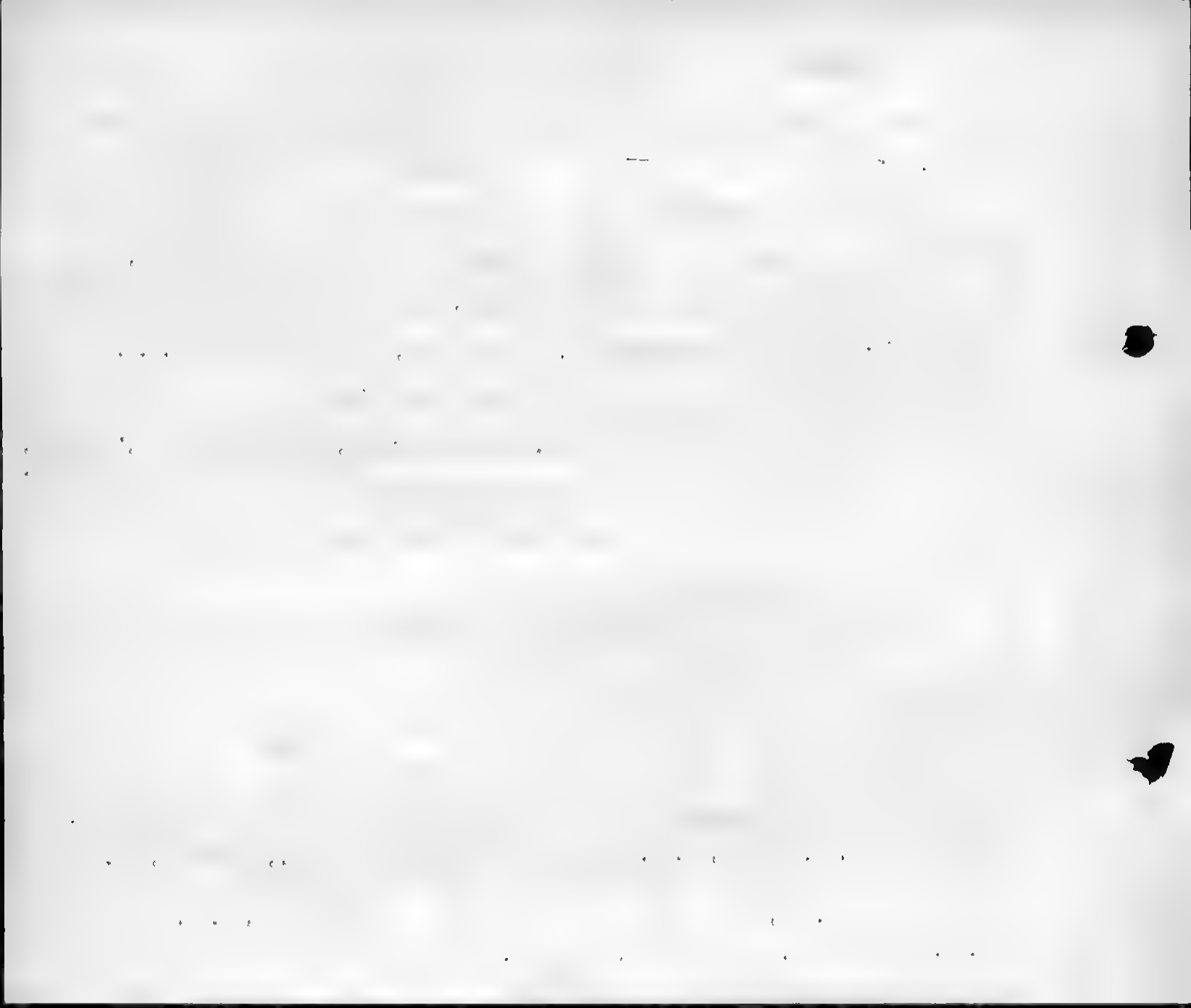


1  
3  
M  
1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

1  
3  
M  
1  
2224  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
022-3

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Green Meadows</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>2029 Roanoke Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>HAROLD</b> Middle <b>(NMN)</b> Last <b>DELCHAMP</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>March 7, 1913</b>	
9. AGE (In years last birthday) <b>47</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>11</b> Hours <b>11</b> Min <b>11</b>		IF UNDER 24 HRS Hours <b>11</b> Min <b>11</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Diamond Cab Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Waterbury, Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Delchamp</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Zinno</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Joseph Delchamp, 10018 Clue Court, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>L</b>		INTERVAL BETWEEN ONSET AND DEATH <b>One hour</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Swirlrosis of the liver &amp; pancreas</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>o. m.</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-21</b> , 19 <b>61</b> , to <b>29</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2-9</b> , 19 <b>61</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>D. R. Purdie</b> M.D.				22b. ADDRESS <b>4408 Queensbury Rd., Riverdale, Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>D. R. PURDIE, M. D.</b>				22d. ADDRESS <b>4408 Queensbury Rd., Riverdale, Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 15, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO.,</b> ADDRESS <b>Riverdale, Maryland.</b>				25a. REC'D BY REGISTRAR <b>FEB 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

222 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

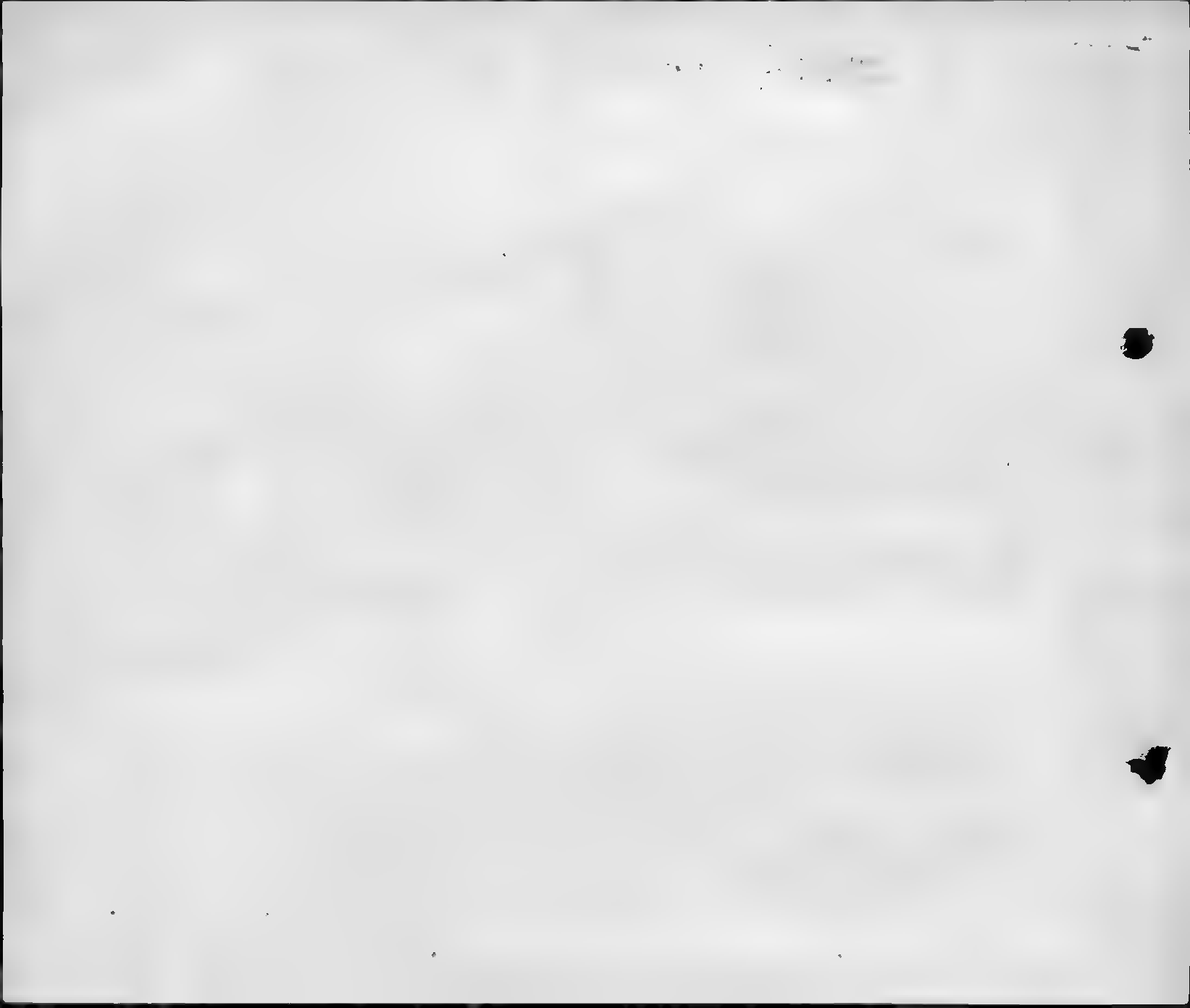
03416

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4612 Lewis Ave		d. STREET ADDRESS 4612 Lewis Ave	
3. NAME OF DECEASED (Type or print) Harry Everett DeSmar		4. DATE OF DEATH Feb 26 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1883
10a. USUAL OCCUPATION (Give kind of work done during most of working life) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own	9. AGE (in years last birthday) 77
13. FATHER'S NAME John Thomas DeSmar		14. MOTHER'S MAIDEN NAME Margaret Richardson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-16-0315	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary insufficiency Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyle		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME (Type) James I. Boyle		ASSISTANT MEDICAL EXAMINER	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 3/1/61	
22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem. Suitland, Md.		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE MAR 13 '61		Arthur S. Kraus	

MEDICAL CERTIFICATION

I

M





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

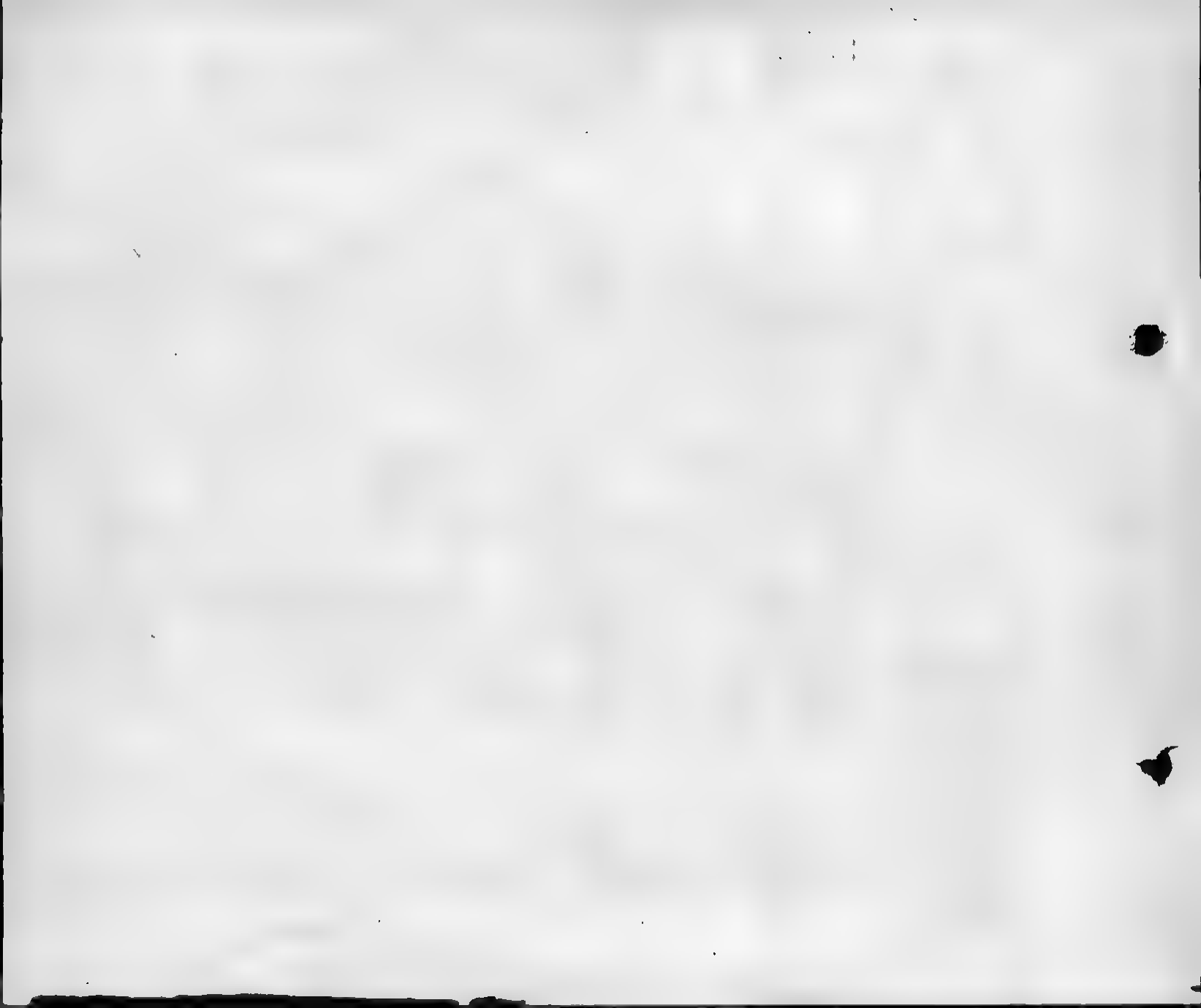
2226

## CERTIFICATE OF DEATH

Reg. Dist. No.

022-4

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE, MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>5402-KENILWORTH AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GERTRUDE</u> Middle <u>ANNE</u> Last <u>DEMERLY</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 10-1871</u>
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>SCRANTON, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN ABLANALP</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA LUTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <input type="checkbox"/>	
17. INFORMANT <u>WILLIAM CALLAGHAN, RIVERDALE AVE</u>		Address <u>5402-KENILWORTH AVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unknow cause. Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/11</u> , 19 <u>61</u> to <u>2/14</u> , 19 <u>61</u> that I last saw the deceased alive on <u>2/14</u> , 19 <u>61</u> , and that death occurred at <u>9:22 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5702 annandale Rd</u> DATE SIGNED <u>4/15/61</u>			
ACTUAL SIGNATURE <u>Barry Rosenberg</u>		PHYSICIAN'S NAME (Type) <u>BARRY ROSENBERG</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/18/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST</u>	22d. LOCATION (City, town, or county) (State) <u>ARMOR NEW YORK 5</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chaffell</u>		ADDRESS <u>475-4-A 27th St. N.W. Wash DC</u>	24a. REC'D BY REGISTRAR DATE <u>FFB 21 '61</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

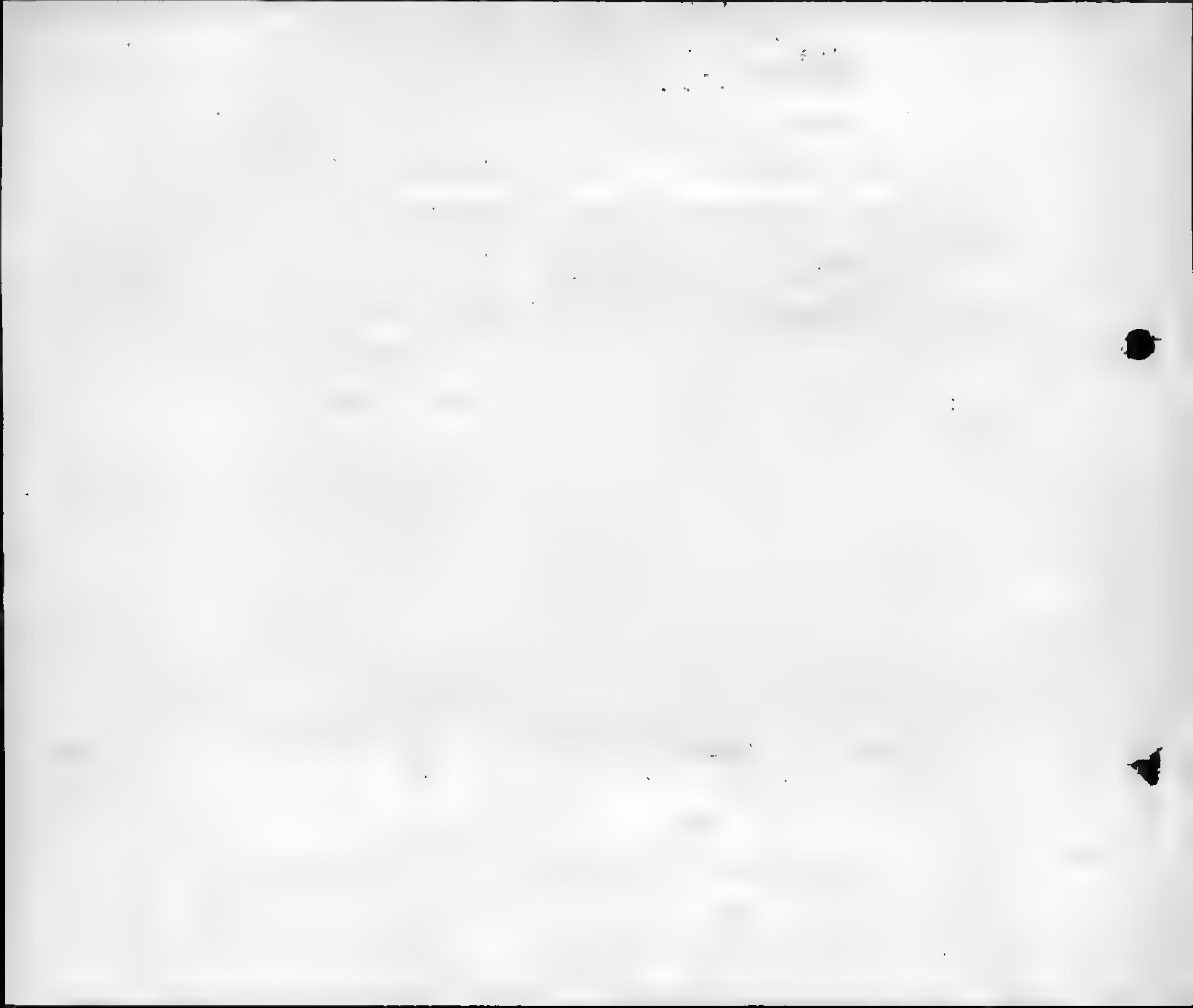


**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02205

2227

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>171</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS AFB WASH 25 DC</b>				d. STREET ADDRESS <b>BASE TRAILER PARK LOT 28</b>					
3. NAME OF DECEASED (Type or print) First <b>DANNY</b> Middle <b>DUANE</b> Last <b>DILLS</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>26</b> Year <b>1961</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAUCASION</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>13 JANUARY 1952</b>		9. AGE (In years lost birthday) <b>9</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
13. FATHER'S NAME <b>WALTER C DILLS</b>				14. MOTHER'S MAIDEN NAME <b>MARY LOU WORK</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>HOSP. RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>323.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Tax-Sachs Disease</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>one month</b> <b>9 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) <b>received</b> the deceased <b>DOA</b> <b>on 26 Feb 1961</b> , that (I) <b>last</b> saw the deceased alive on <b>26 Feb 1961</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>John F. Bridgeman</b> M.D.				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>26 Feb 61</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN F BRIDGEMAN, CAPT USAF (MC)</b>				22d. ADDRESS <b>USAF HOSPITAL, ANDREWS AFB, WASH 25, DC</b>					
23a. MANNER OF REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1 MARCH 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kinall Funeral Home, Inc.</b>				ADDRESS <b>816 H St. N.E. D.C. 22</b>		25a. REC'D BY REGISTRAR <b>FEB 28 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Walter L. Kenna</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
TSM 9-59

2228  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02206

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Washington, DC.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR-4922 LA SALLE</b>		e. STREET ADDRESS <b>4607-CONN. AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>MISS SARAH - MAGDELINE - DOUGHERTY</b>		4. DATE DEATH <b>FEBRUARY 17</b> 19 <b>61</b>	
5 SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 4, 1895</b> 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOVERNMENT WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pittsburg, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pittsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>YES - U.S.A.</b>	
13. FATHER'S NAME <b>DAVID FRANCIS DOUGHERTY</b>		14. MOTHER'S MAIDEN NAME <b>MARY TOLAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Sister M. Dominic Catherine - 4922 La SALLE Rd. Hyattsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Parkinsonism &amp; weakness of muscles &amp; dysphagia</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1) congestive heart failure</b> 2) <b>Parkinsonism severe</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Sept 1957</b> to <b>2/17, 1961</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>2/16, 1961</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>Edward J Pacious</b>		22b. DATE SIGNED <b>2/17/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>EDWARD J PACIOUS</b>		22d. ADDRESS <b>1746 K ST. N.W. Wash, DC.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-18-1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT OLIVET CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons, Wash, DC.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 20 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>William L. Hines</b>			

M

I



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

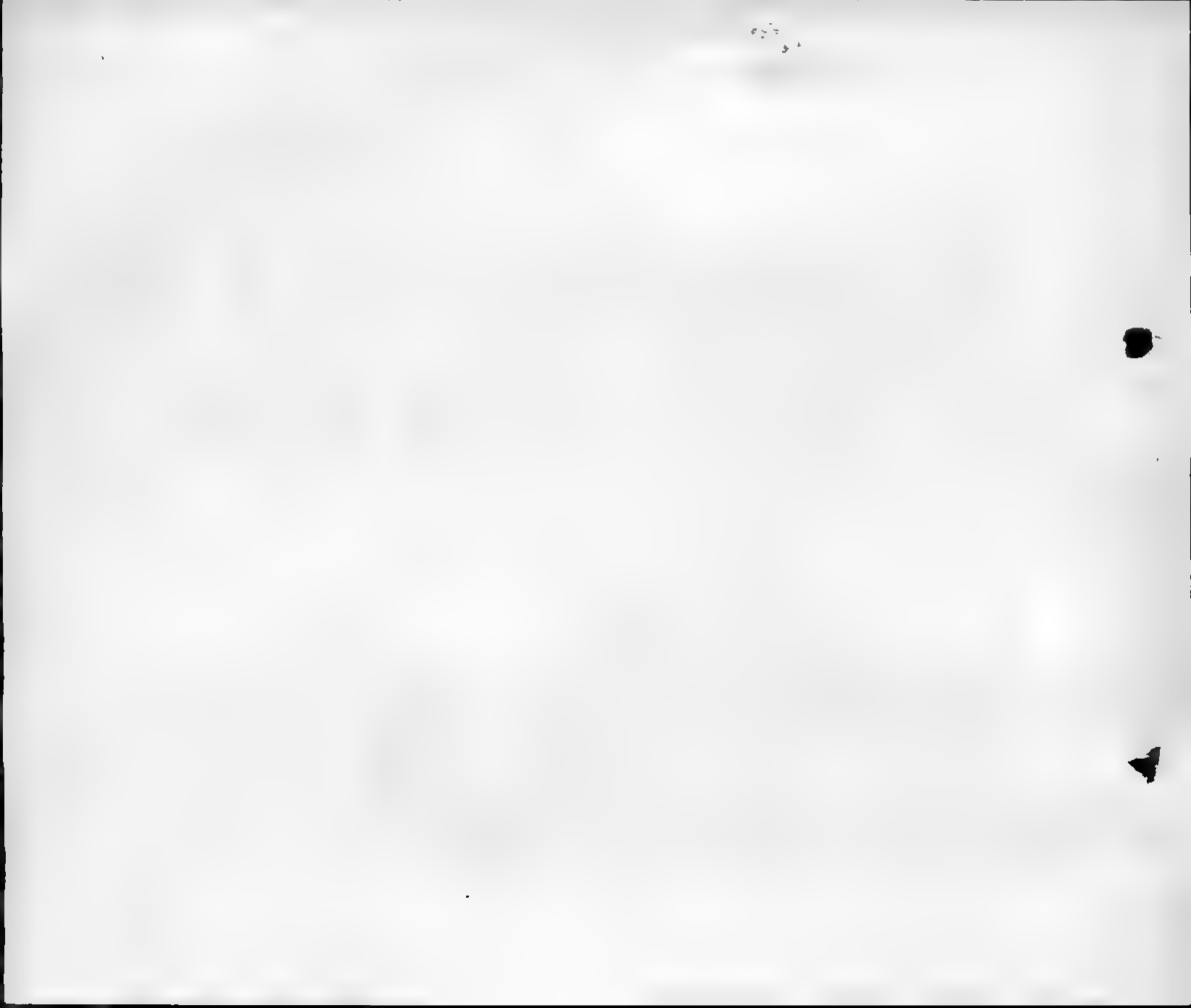
VR A15 (4)  
ISM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2229		02207	
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AGUASCO</u>		c. LENGTH OF STAY IN 1b <u>X</u> CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AGUASCO</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BABY BOY</u> Middle <u>DOUGLAS</u> Last <u>DOUGLAS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-61</u>
9. AGE (In years last birthday) <u>—</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>15</u>	11. IF UNDER 24 HRS Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>AGUASCO, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A. Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Louise Douglas</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>John A. Carroll</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUFFOCATION</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>		21. I certify that (I) ( <u>this hospital</u> ) attended the deceased from <u>—</u> 19 <u>—</u> to <u>2-6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>—</u> 19 <u>—</u> , and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Richard H. Dotson</u> M.D.		22b. DATE SIGNED <u>2-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. DOTSON, M.D.</u>		22d. ADDRESS <u>BRANDY WINE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>John Weekey M.E.</u>	23d. LOCATION (City, town or county) (State) <u>AGUASCO, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>George G. Nelson-Aguasco, Md.</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	
DATE <u>FEB 10 '61</u>		DATE <u>FEB 10 '61</u>	





2230

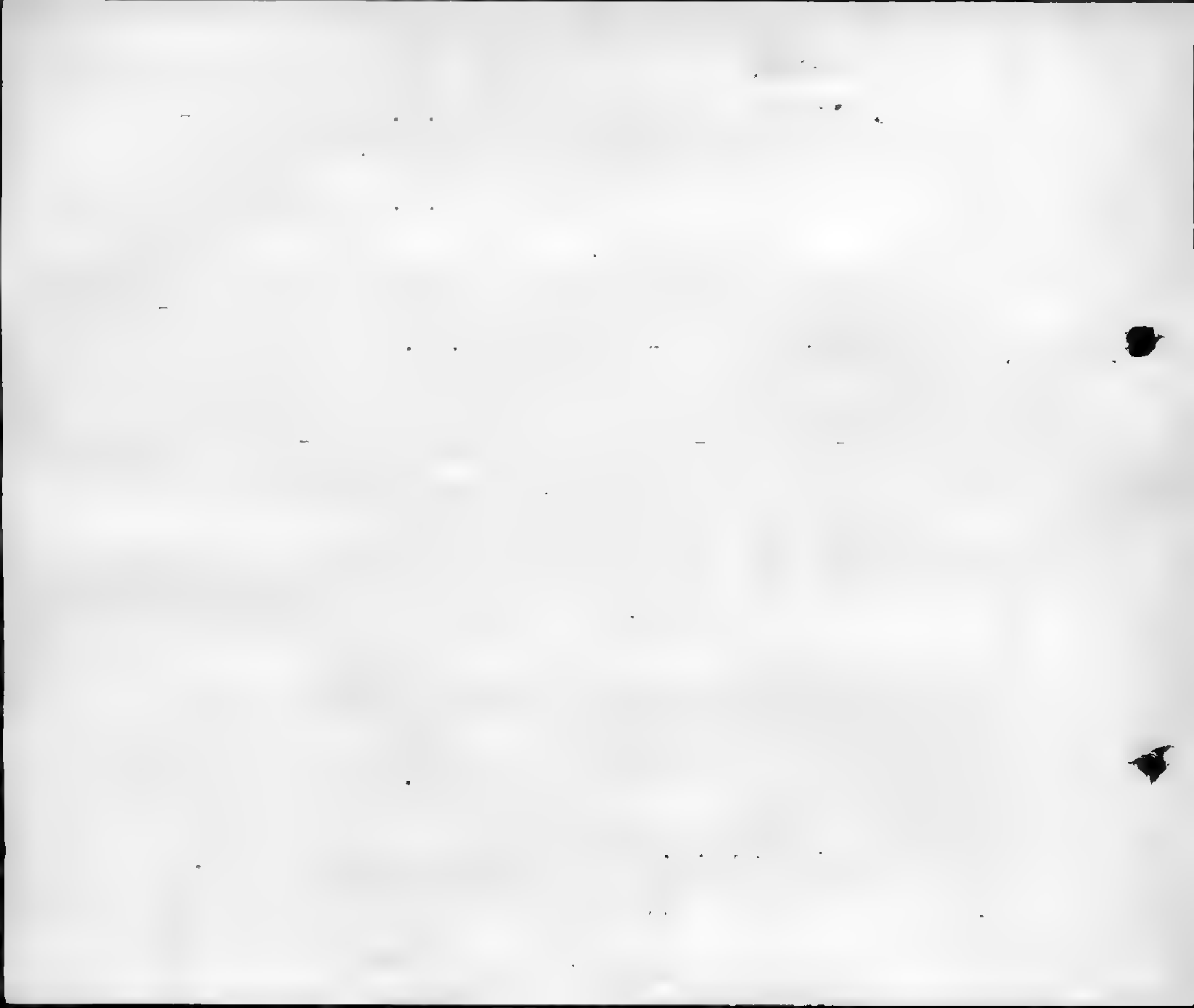
MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

022 18

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 6 months & 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS D. C. Village			
3. NAME OF DECEASED (Type or print) First Middle Last Juanita L. Duncan				4. DATE OF DEATH Month Day Year 2 4 19 61			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/27/09	
9. AGE (In years last birthday) 51 yrs		10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) General housework		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Duncan		14. MOTHER'S MAIDEN NAME Lena ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Arteriosclerotic heart disease with congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): Chronic rheumatoid arthritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/27/1960 to 2/4/1961 that (I) (we) last saw the deceased alive on 2/4/1961, and that death occurred at 2:58 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				M. D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/4/1961	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/9/61		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City town or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert J. McNamee				25a. REC'D BY REGISTRAR DATE FEB 8 '61		25b. REGISTRAR'S SIGNATURE C. S. Kraw	

WASHINGTON D.C.



CERTIFICATE OF DEATH

Reg. Dist. No. 03420

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellsville, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Rt 2 Box 36</u>	
3. NAME OF DECEASED (Type or print) First <u>Oscar</u> Middle <u>H</u> Last <u>Entzian</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-01</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming Tobacco</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rudolph Entzian</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Unknown Bauer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Josephine Entzian</u>		Address <u>Rt 2, Box 36 Mitchellsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>4 months</u> ONSET AND DEATH <u>10 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		(County) (State)	
21. I certify that I attended the deceased from <u>Dec. 24</u> , 19 <u>60</u> , to <u>Feb. 20</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>61</u> , and that death occurred at <u>3:15</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>RT #1 Box 277 - M Edgewater, Md.</u> DATE SIGNED <u>2/20/61</u>			
ACTUAL SIGNATURE <u>Sylvia M. Kim</u>		PHYSICIAN'S NAME (Type) <u>Sylvia M. Kim</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/23/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Biss</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
2232  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02249

1. PLACE OF DEATH a. COUNTY Prince Geo MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Prince Geo 34	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park Hyattsville 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deland Mem Hosp		d. STREET ADDRESS 8106 Pembroke Pl e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leon Richard Faircloth		4. DATE OF DEATH February 9 81	
5. SEX m	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-12-1901
9. AGE (In years last b'day) 59 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY E.H. WALKER CO.	
11. BIRTHPLACE (State or foreign country) N. CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Wesley Faircloth		14. MOTHER'S MAIDEN NAME Rich, Harriett E	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-01-5638	
17. INFORMANT Hosp. Rec. & Daughter.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 260X DUE TO Cerebral Artery occlusion right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROSIS - (c) DUE TO DIABETES Mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) gonevrene of both feet		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 1 1961 to Feb 8 1961, that (I) (we) last saw the deceased alive on Feb 9 1961, and that death occurred at 8:30 AM, from the causes and on the date stated above			
22a. SIGNATURE R. Williamson M.D.		22b. DATE SIGNED 2-9-61	
22c. PHYSICIAN'S NAME (Type) R. WILLIAMSON		22d. ADDRESS Deland Memorial Hospital, Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-11-1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		ADDRESS Riverdale, Md.	
25a. REC'D BY REGISTRAR DATE FEB 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. H.	



2233

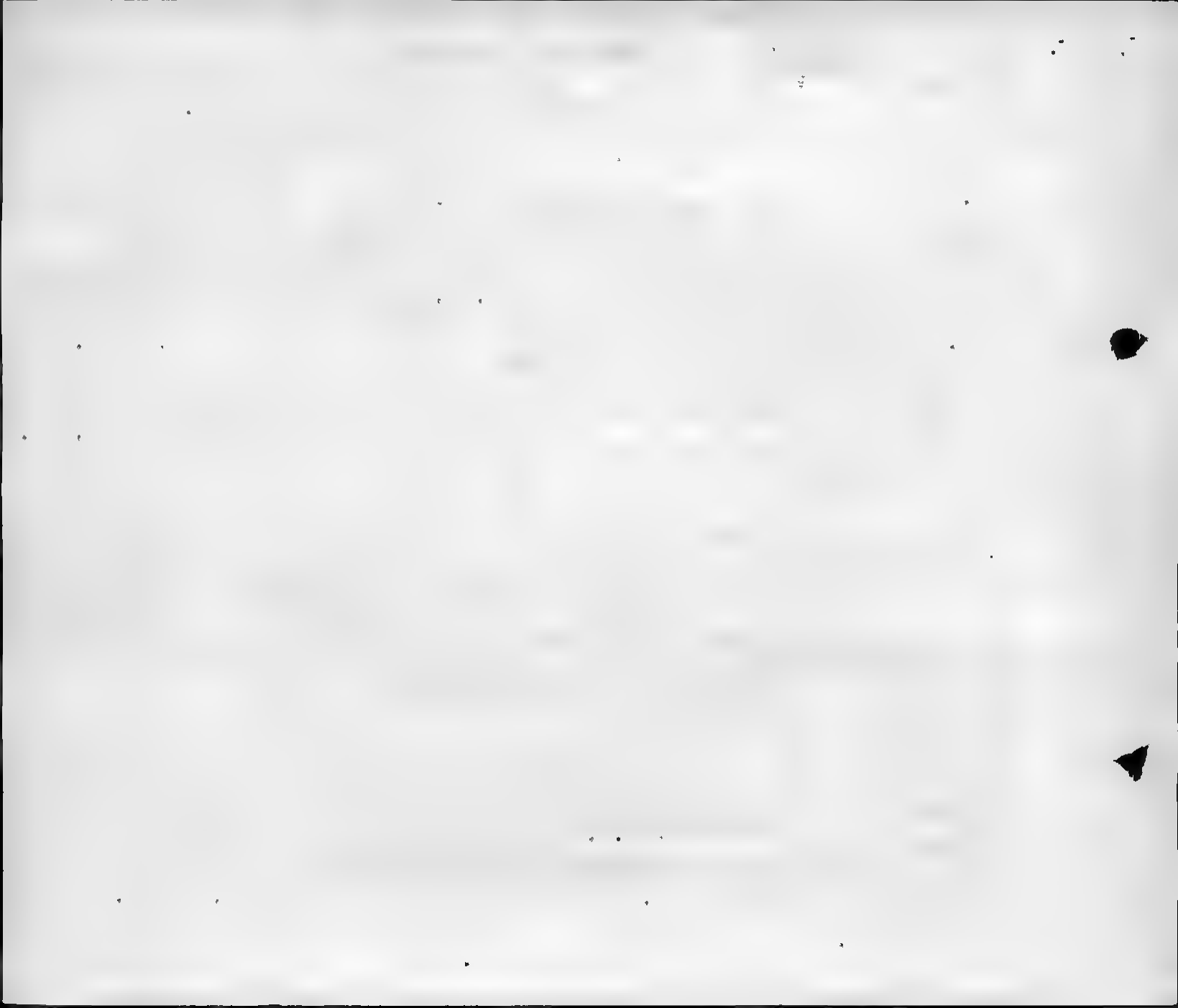
## CERTIFICATE OF DEATH

Reg. Dist. No. 03422

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Meadows	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. Geo's County Rest Home		d. STREET ADDRESS ---	
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Ferguson		4. DATE OF DEATH Month February Day 25, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1884
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Farming		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elijah Ferguson		14. MOTHER'S MAIDEN NAME Victoria Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO 17. INFORMANT Harvey Leon Ferguson Upper Marlboro, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Acute Congestive Cardiac failure DUE TO (b) Arteriosclerotic myocarditis DUE TO (c) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 1 hr Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Hypochromic Anemia & Dursden Unknown		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Natural Causes		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Natural Causes	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> FBI while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 15, 1961, to Feb 25, 1961, that I last saw the deceased alive on Feb 24, 1961, and that death occurred at 2:45 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul C. VanNatta, M.D.		ADDRESS (Street, city or town, state) 5440 Silver Hill Rd SE Washington 28 DC	
DATE SIGNED 2/25/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/61	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE MAR 13 '61	
24b. REGISTRAR'S SIGNATURE Curtis L. Flann			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02210

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>14 Bowie</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>		d. STREET ADDRESS <u>15th and Chestnut Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CATHERINE FLETCHER</u>		4. DATE OF DEATH Month Day Year <u>FEB 25 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-4-95</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Grayson</u>		14. MOTHER'S MAIDEN NAME <u>Walter Wood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>4374 Dubois St.</u>	
17. INFORMANT <u>Clara Marshall</u>		Address <u>4374 Dubois St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO (b) <u>PRIMARY CANCER IN THE GALLBLADDER</u> DUE TO (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>61</u> , to <u>2-25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>FEB 25</u> , 19 <u>61</u> , and that death occurred at <u>12</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>R. B. Sasser</u>		22b. DATE SIGNED <u>2-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. R. Sasser</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-1-61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Church of the Resurrection</u>		23d. LOCATION (City, town, or county) (State) <u>Bowie Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Barnes &amp; Matthews</u>		25a. REC'D BY REGISTRAR <u>3619-14 St NW</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>		DATE <u>FEB 27 '61</u>	



1

2235

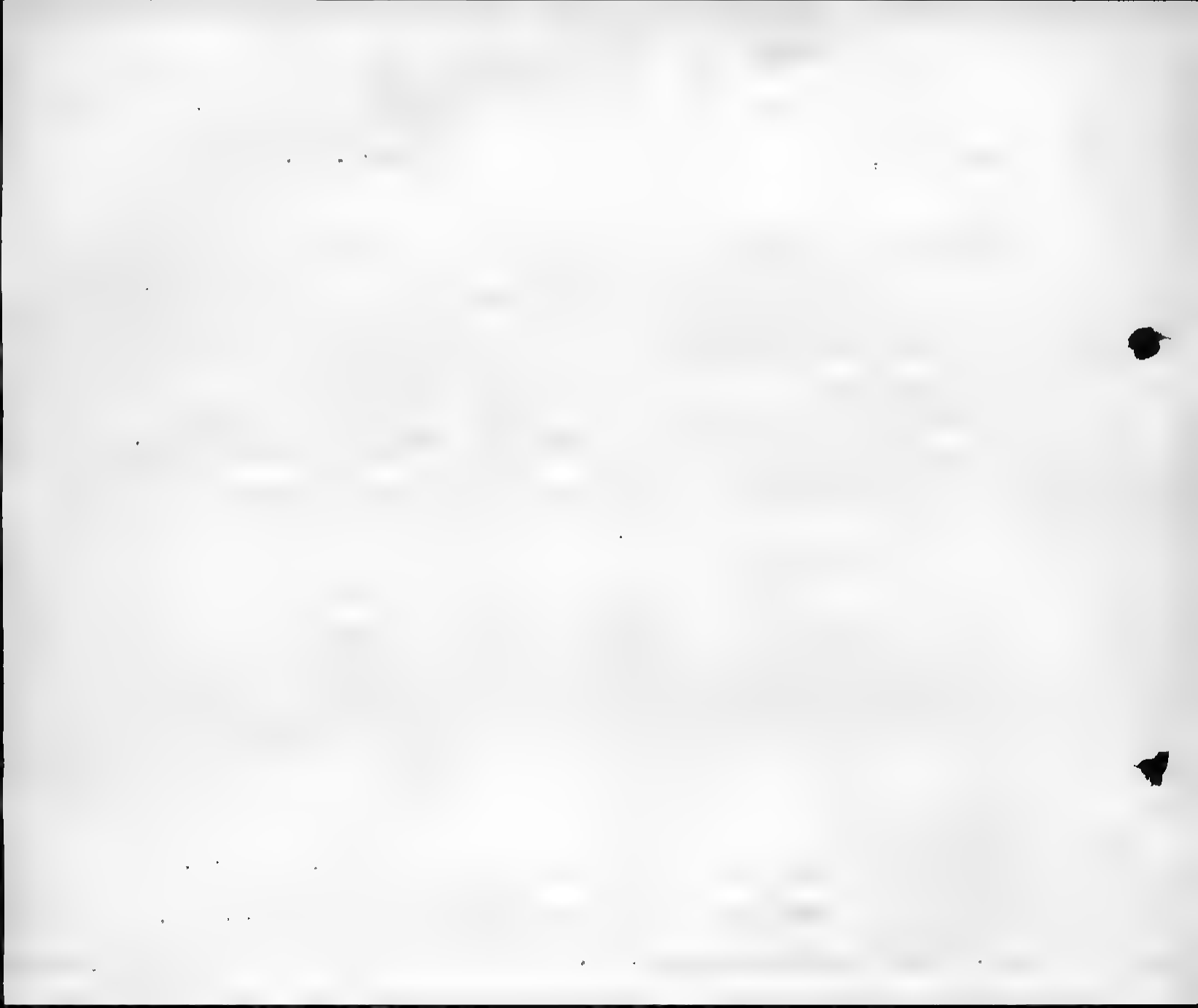
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02211

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print): <b>Charles</b> First <b>Irving</b> Middle <b>Flory</b> Last		4. DATE OF DEATH <b>February</b> Month <b>7,</b> Day <b>19 61</b> Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1876</b>
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Church</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Flory</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Cost</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
INFORMANT <b>Maurice Flory</b> Address <b>Seabrook Maryland.</b>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident H. I. I.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerosis general</b> (c) <b>hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Arteriosclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 19 60</b> to <b>2/7 1961</b> that I last saw the deceased alive on <b>2/7 1961</b> and that death occurred at <b>8:15</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>RFD Bowie Md</b> DATE SIGNED <b>2/7/61</b>			
ACTUAL SIGNATURE <b>H. James</b> M.D.		PHYSICIAN'S NAME (Type) <b>H. James</b> <b>R F D Bowie, Maryland.</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 10, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 '61</b>	
ADDRESS <b>Hyattsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



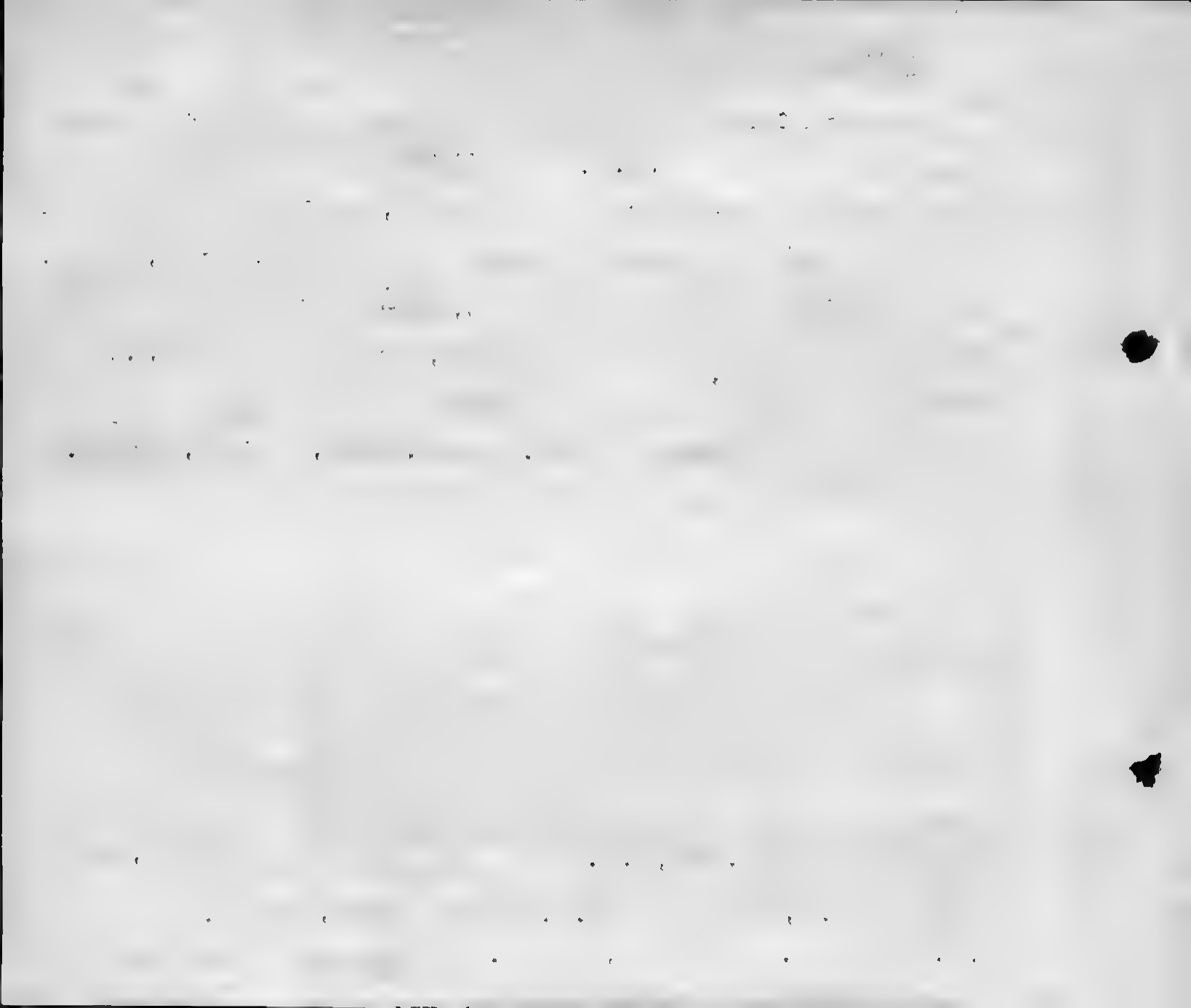
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. 5ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02212									
1. PLACE OF DEATH a. COUNTY Prince George County					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly					b. COUNTY Prince Georges				
c. LENGTH OF STAY IN 1b D. O. A.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital					d. STREET ADDRESS Route #2, Box 415				
3. NAME OF DECEASED (Type or print) NORRIS CAMPBELL FOWLER					e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX Male					4. DATE OF DEATH February 9, 19 61.				
6. COLOR OR RACE White					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH July 17, 1891					9. AGE (In years last birthday) 69 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					11. BIRTHPLACE (State or foreign country) Lanham, Maryland				
10b. KIND OF BUSINESS OR INDUSTRY General					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Unknown					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None					16. SOCIAL SECURITY NO. 517-10-4927				
17. INFORMATION Mrs. Gladys M. Fowler, Clinton, Maryland.					Address: Route 2 Box 415				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 491X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) Bronchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 9, 1961									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.									
Address (Street, city, town, or county)									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
22b. DATE THEREOF Feb. 14, 1961									
22c. NAME OF CEMETERY OR CREMATORY Lanham Meth. Ch. Cemetery									
22d. LOCATION (City, town, or country) (State) Lanham, Maryland.									
23. FUNERAL DIRECTOR W. W. CHAMBERS CO. Riverdale, Maryland.									
24a. REC'D BY REGISTRAR DATE Feb 14 1961									
24b. REGISTRAR'S SIGNATURE Arthur L. Hume									



may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02213

2237

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>4 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>			
				d. STREET ADDRESS <b>Post Office Box 201</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Frances</b> Last <b>Frazier</b>				4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-6-32</b>		9. AGE (In years last birthday) <b>28</b> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Carter</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Nicley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown (If yes, give war or dates of service) <b>-----</b>				16. SOCIAL SECURITY NO <b>-----</b>		17. INFORMANT <b>Osby F Frazier</b> Address <b>Waldorf, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>671X</b> DUE TO <b>Int pulm edema</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Profound anemia</b> (c) <b>fractured plac. fragments</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/13</b> , 19 <b>61</b> , to <b>2/13</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>61</b> , and that death occurred <b>6:35 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Albert Roth</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. ALBERT ROTH</b>				22d. ADDRESS <b>5510 Madison-Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL. (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/16/61</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) <b>Rockbridge County, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The L. H. Thomas Co</b>				ADDRESS <b>2901-14th St. N.E.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 20 '61</b>	
						25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

(M)

(I)





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

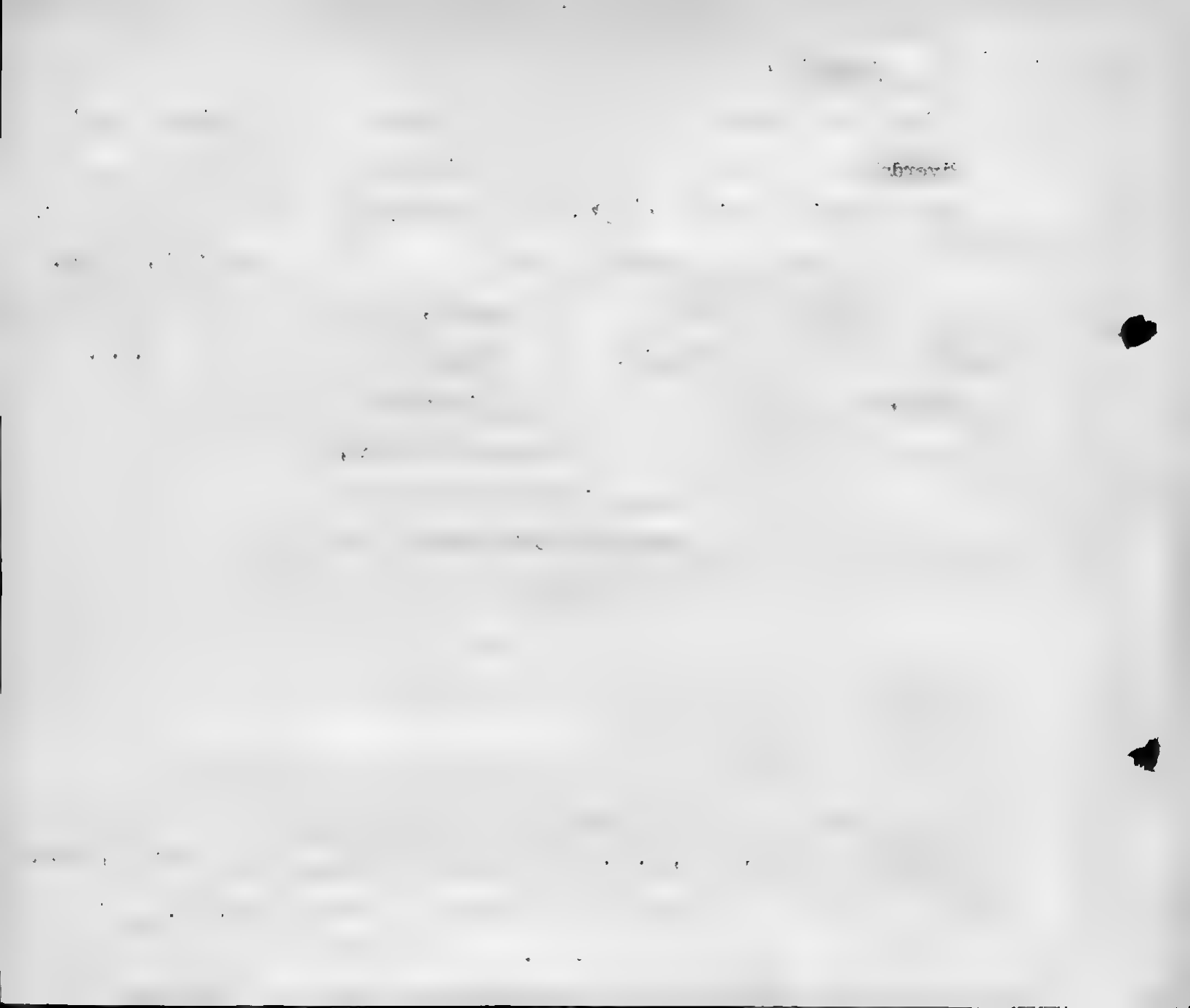
VS. A15ME  
5M 7/59

2238  
MAYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02214

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b> c. LENGTH OF STAY IN 1b <b>Leland Memorial Hospital</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>104 D Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EARL RICHARD GAHLE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1908</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Man</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Gahle</b>				14. MOTHER'S MAIDEN NAME <b>Minerva Utz</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Mrs Elizabeth Gahle, Same as # 2</b>			
17. INFORMANT <b>Mrs Elizabeth Gahle, Same as # 2</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>February 23, 1961.</b>							
ACTUAL SIGNATURE <b>JAMES I. BOYD, M. D.</b>		DATE SIGNED					
EXAMINER'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>Feb 25, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Md.</b>			
23. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 27 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Huns</b>	

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2239

02215

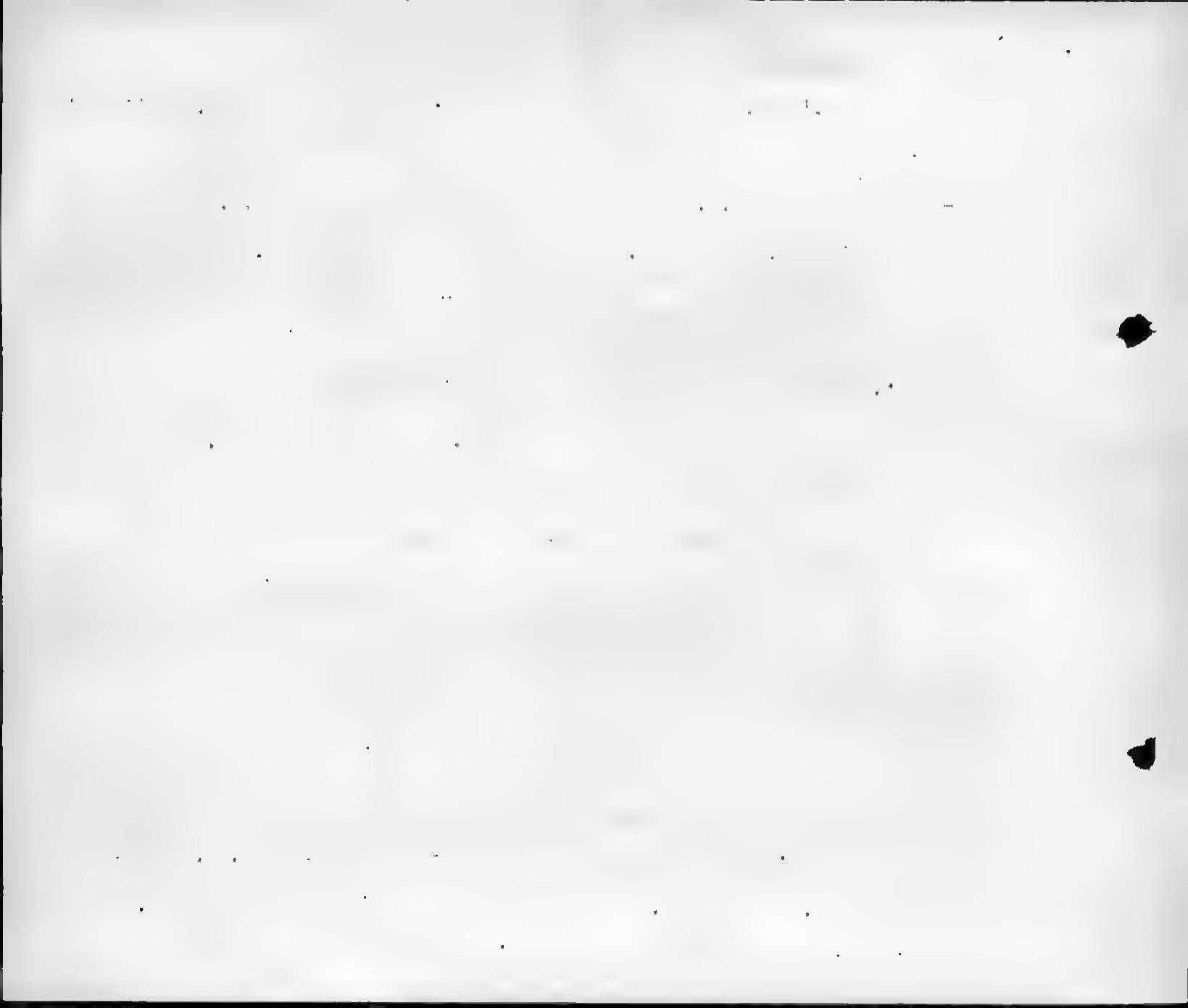
1 PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silesia	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8600- River View Road S.E.		d. STREET ADDRESS 8600- River View Road S.E.	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Theodore P. Gates		4. DATE OF DEATH Month Day Year Feb. 18th 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH April 17- 1886
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Phillip H. Gates		14 MOTHER'S MAIDEN NAME Annie Spencer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Ernest W. Gates		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Scurvy to 420 DUE TO Cirrhosis Liver Chronic Poisoning 1 Yr Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO (b) Arterio Sclerotic Heart Disease 11 Yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 1 Yr 11 Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Old Coronary Infarction 1949		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Jan. 14 1961 to 2-18 1961, that (I) (we) last saw the deceased alive on 2-17 1961, and that death occurred at 12 P. M. from the causes and on the date stated above.			
22a SIGNATURE John J. Calarco M.D.		22b DATE SIGNED 2-18-61	
22c PHYSICIAN'S NAME (Type) John J. Calarco		22d ADDRESS 3301- Suitland Road S. E. Wash., DC	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Feb. 21st 61	
23c NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d LOCATION (City, town, or county) (State) Piscataway, Maryland.	
24 FUNERAL DIRECTOR'S SIGNATURE Simmons Brothers		25a REC'D BY REGISTRAR FEB 20 '61	
1661- Good Hope Rd. SE Washington, DC		25b REGISTRAR'S SIGNATURE Arthur S. Hume	

(M)

X

(I)

MEDICAL CERTIFICATION



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2240 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02216									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Pennsylvania</b>				
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Bowie</b>					c. LENGTH OF STAY IN b <b>Lancaster</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pa RR Spur to Bowie Racetrack</b>					d. STREET ADDRESS <b>615 North Duke Street</b>				
3. NAME OF DECEASED (Type or print) <b>BENJAMIN FRANKLIN GOOD III</b>					4. DATE OF DEATH Month Day Year <b>February 2, 19 61.</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>					8. DATE OF BIRTH Month Day Year <b>July 8, 1924</b>				
9. AGE (In years last birthday) <b>36</b> yrs					10. AGE (In years last birthday) Months Days Hours Min. <b>36</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Home Life Ins. Co of America.</b>				
11. BIRTHPLACE (State or foreign country) <b>Lancaster, Pennsylvania</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>BENJAMIN FRANKLIN GOOD</b>					14. MOTHER'S MAIDEN NAME <b>Florence Trissler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WWII</b>					16. SOCIAL SECURITY NO <b>184-12-6145</b>				
17. INFORMANT <b>Florence Trissler</b>					Address <b>615 N. Duke St., Lancaster, Pa.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b>									
DUE TO (b) <b>Fracture of the skull</b>									
DUE TO (c) <b>Fracture of the skull</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <b>Passenger in a train that ran off the track</b>									
20c. TIME OF INJURY Month, Day, Year <b>1:00 p.m. 2/2/ 61</b>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> <b>Train</b>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Jerricho Park P. G. Md.</b>									
20f. (City or town) (County) (State) <b>Jerricho Park P. G. Md.</b>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
Address (Street, city, town, or county) <b>February 2, 1961.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>									
22b. DATE THEREOF <b>Feb. 6, 1961</b>									
22c. NAME OF CEMETERY OR CREMATORY <b>Lancaster</b>									
22d. LOCATION (City, town, or country) (State) <b>Lancaster, Pennsylvania</b>									
23. FUNERAL DIRECTOR ADDRESS <b>W. W. CHAMBERS CO., Riverdale, Maryland.</b>									
24a. REC'D BY REGISTRAR <b>FEB 8 '61</b>									
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>									

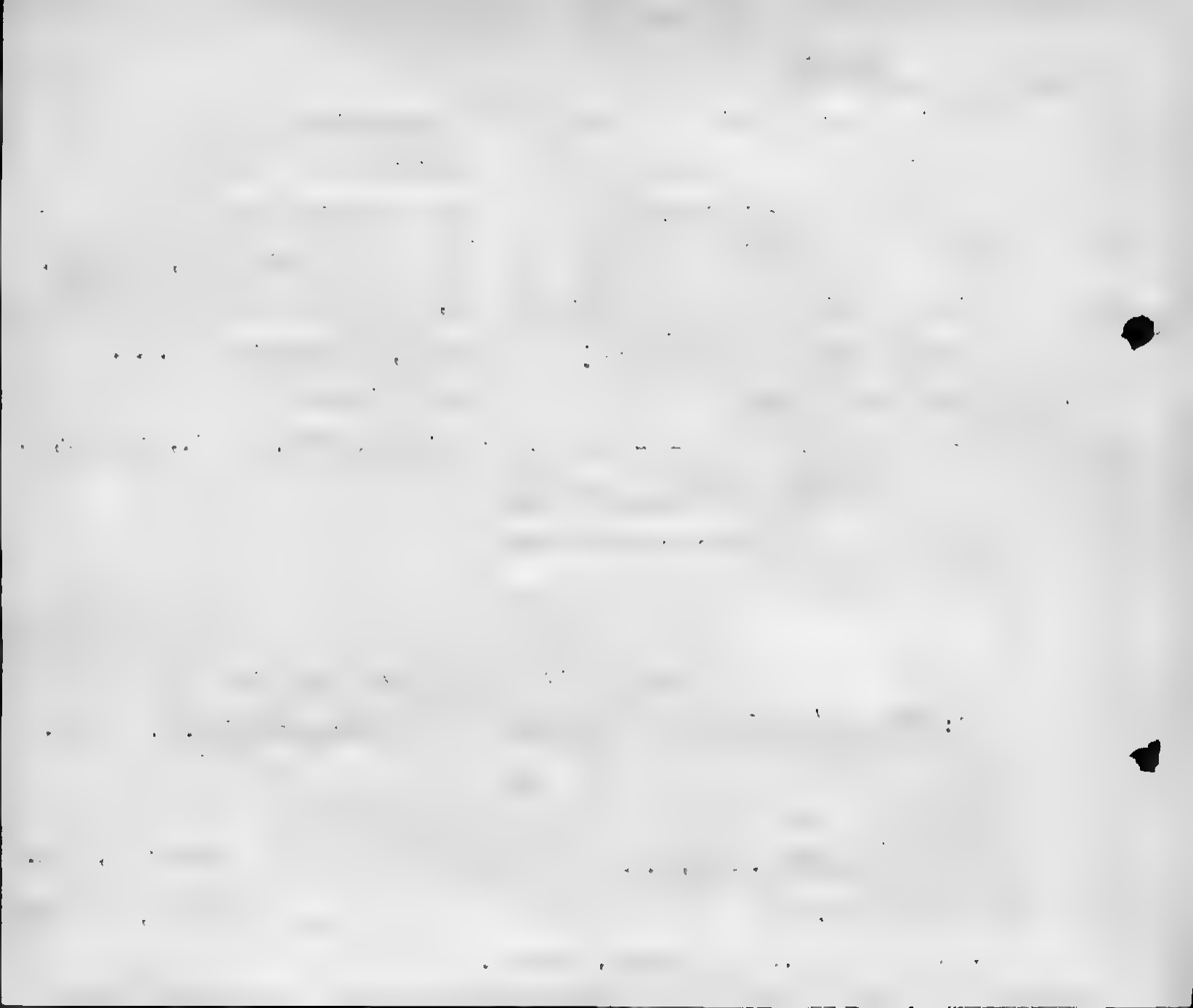
EXAMINER'S NAME (Type)  
**JAMES I. BOYD, M.D.**

22b. DATE THEREOF  
**Feb. 6, 1961**

22c. NAME OF CEMETERY OR CREMATORY  
**Lancaster**

24a. REC'D BY REGISTRAR  
**FEB 8 '61**

24b. REGISTRAR'S SIGNATURE  
**Arthur S. Harris**



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

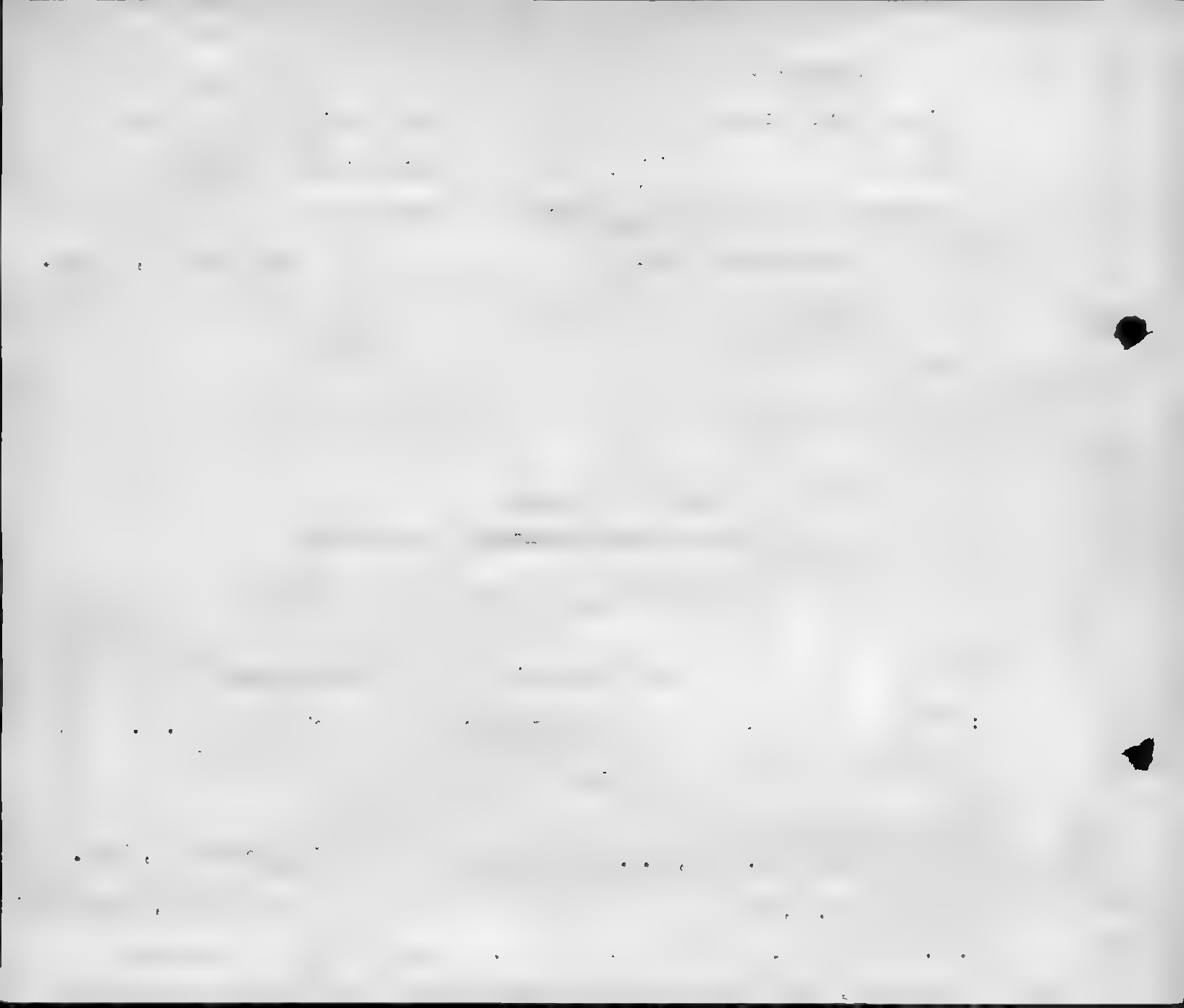
VS. A15ME  
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02217

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> c. LENGTH OF STAY IN IL <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Pa RR Spur on track to Bowie Racetrack</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Chester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Spring City</b> d. STREET ADDRESS <b>RD #1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BENJAMIN R. GRADY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 61.</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>APRIL 9, 1917</b>		9. AGE (in years last birthday) <b>43</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>61</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAINTER</b>		12. KIND OF BUSINESS OR INDUSTRY <b>CONTRACTOR</b>		13. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
14. FATHER'S NAME <b>BENJAMIN M. GRADY</b>		15. MOTHER'S MAIDEN NAME <b>SADIE JENKINS</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO <b>UNKNOWN</b>		19. INFORMANT <b>EDNA S. GRADY RD #1</b> Address <b>SPRING CITY</b> <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Severance of the head at the shoulders</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18) <b>Passenger of a train that ran off the track</b>			
20c. TIME OF INJURY Month, Day, Year <b>1:00 p.m. 2/2/ 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Railroad train</b>	
20f. (City or town) <b>Jerricho Park P. G.</b>		20g. (County) <b>Md</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>February 2, 1961.</b>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parker Ford, Pennsylvania</b>	
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO.,</b>		ADDRESS <b>Riverdale, Maryland.</b>		24a. REC'D BY REGISTRAR <b>FEB 8 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	





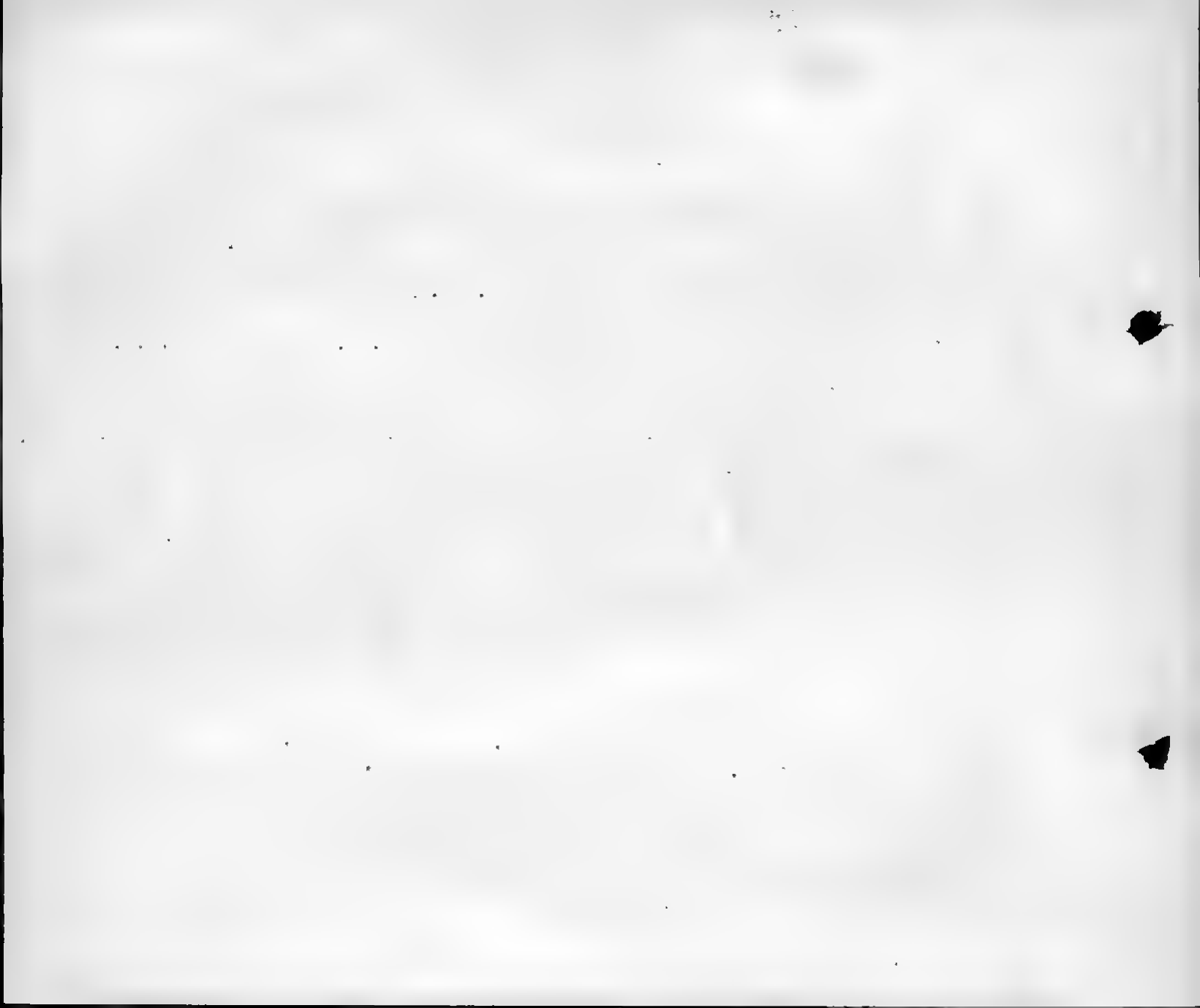
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician or completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02218

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN lb <b>3 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> d. STREET ADDRESS <b>Church Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jerry</b> First Middle Last <b>Green</b>		4. DATE OF DEATH Month Day Year <b>Feb. 2 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 23. 1904</b>
9. AGE (In years last birthday) yrs <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>3 days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horse Trainer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brooklyn, N. Y.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jerry Green, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO <b>152-14-2607</b>	
17. INFORMANT <b>John Boneface - Box 2626, Arlington Sta. 15, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO <b>433-1</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardio-Vasc. Disease</b> DUE TO <b>Chronic Atrial fibrillation</b> (c) <b>Chronic Atrial fibrillation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 29 1961</b> to <b>Feb. 2 1961</b> that (I) (we) last saw the deceased alive on <b>Feb. 1 1961</b> and that death occurred on <b>Feb. 2 1961</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles R. Law</b> M.D.		22b. DATE SIGNED <b>Feb. 6 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles R. Law</b>		22d. ADDRESS <b>3101 ARUNDEL RD MT. LAIMER MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-4-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arbutus Memorial Park</b>		23d. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b>		25a. REC'D BY REGISTRAR <b>6 '61</b>	
ADDRESS <b>802 Madison Avenue</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>	

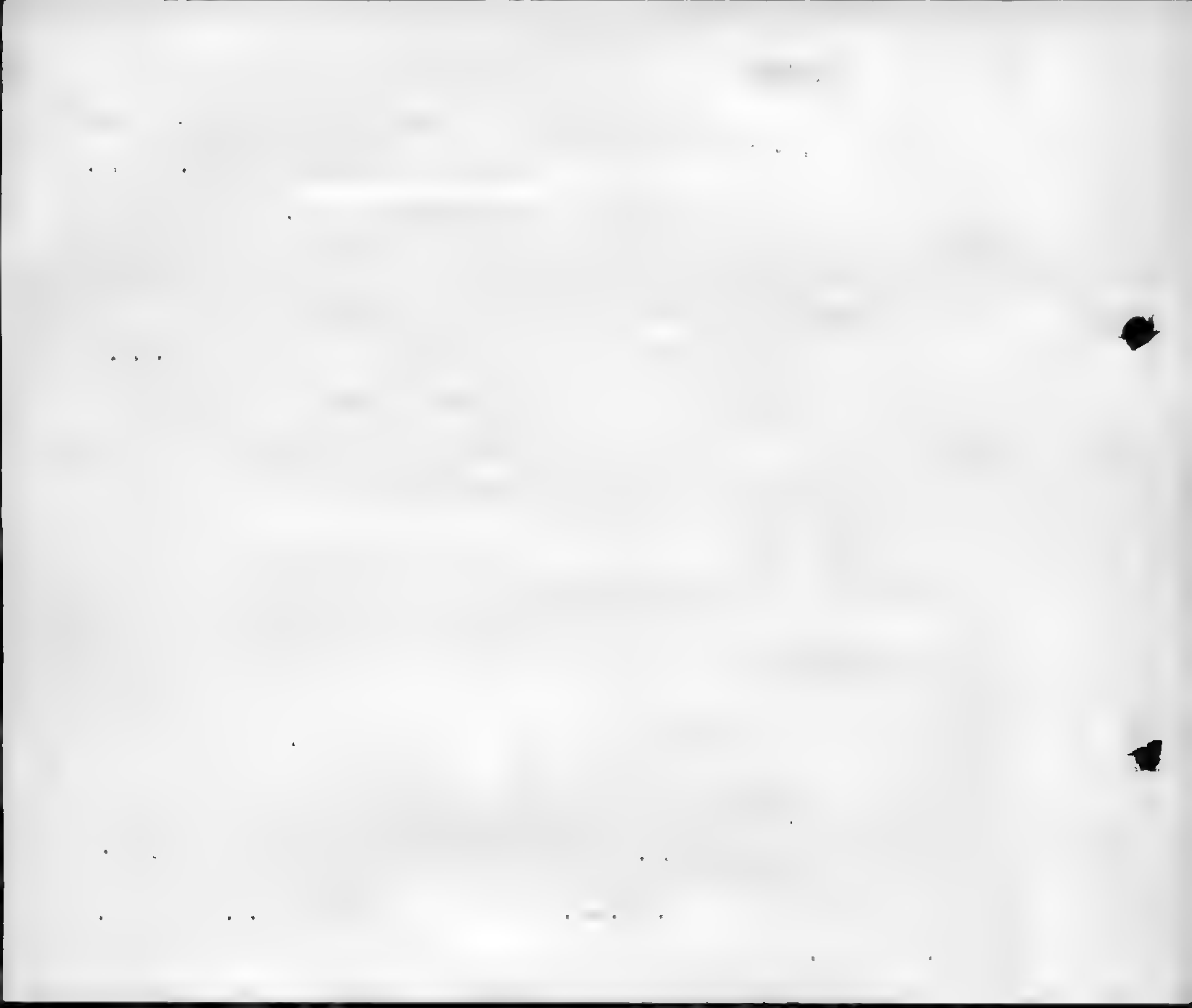


1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02219

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>22hrs 27 Min</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George's General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Baby Boy Greer</b>				4. DATE OF DEATH <b>February 13 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/12/61 - 9:48PM</b>	
9. AGE (In years last birthday) <b>22</b>		10. IF UNDER 1 YEAR Months <b>22</b> Days <b>27</b>		11. IF UNDER 24 HRS. Hours <b>22</b> Min. <b>27</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William M Greer</b>				14. MOTHER'S MAIDEN NAME <b>Minnie Gross</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Atelectasis</b> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 12 1961</b> to <b>Feb. 13 1961</b> that (I) (we) last saw the deceased alive on <b>Feb 13 1961</b> and that death occurred at <b>8:15 P. M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>John Perkins</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>Dr John Perkins M.D.</b>	
22d. ADDRESS <b>5301 Hamilton St, Hyattsville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2/28/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pr. Geo. Gen. Hospital</b>		23d. LOCATION (City, town, or county) (State) <b>Cheverly, P.G. County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HARRY W. PENN, ADM</b>				25a. REC'D BY REGISTRAR <b>MAR 7 '61</b>		25b. REGISTRAR'S SIGNATURE <b>L. Frank</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

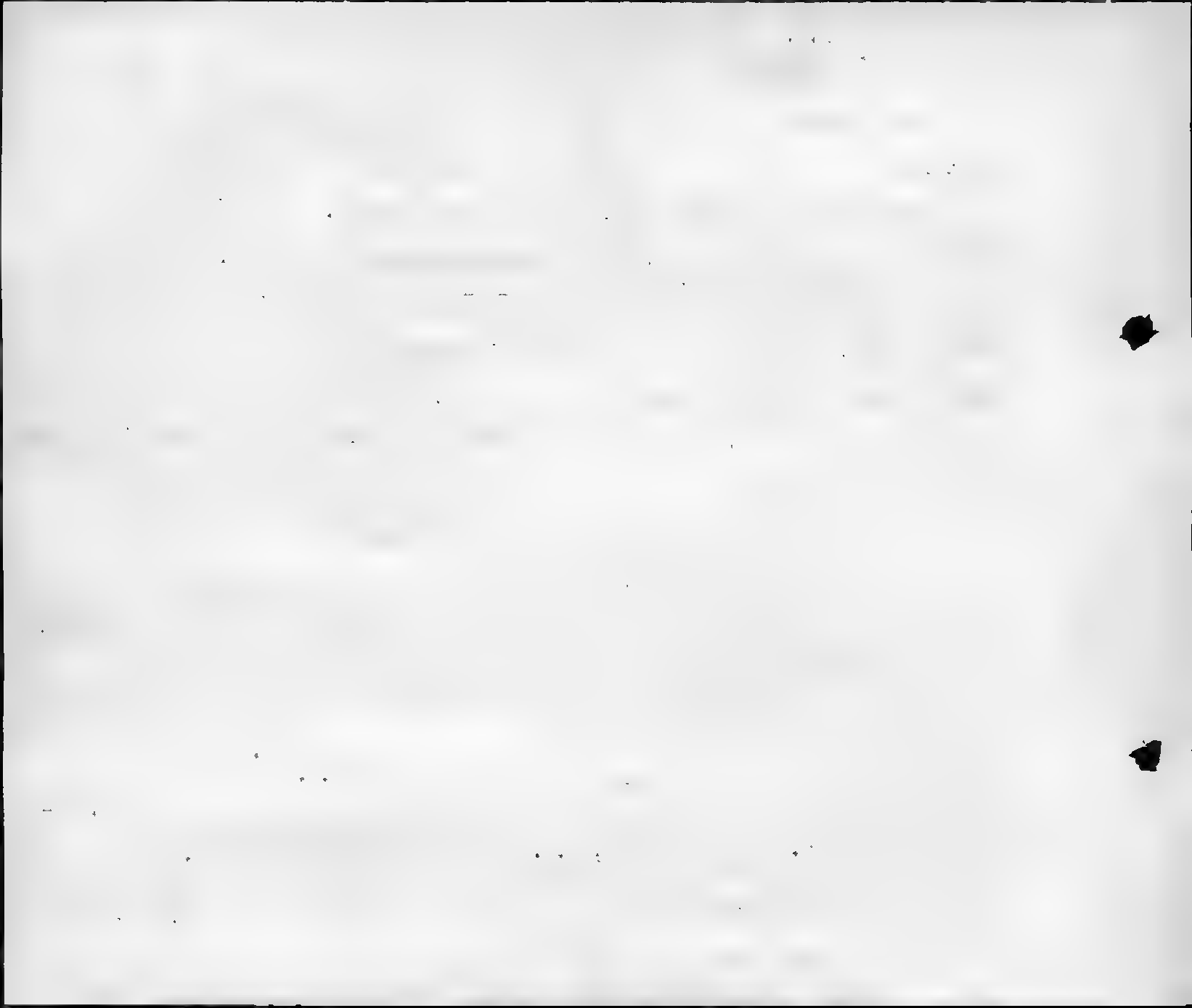
**CERTIFICATE OF DEATH**

2244

02241

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>				c. LENGTH OF STAY IN 1b <b>3 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Eugene</b> Middle <b>J</b> Last <b>Gundersheimer</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-11-10</b>	
9. AGE (In years last birthday) <b>50 yrs.</b>		10. IF UNDER 1 YEAR Months <b>50</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUS DRIVER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>GREY LINE</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
13. FATHER'S NAME <b>HENRY GUNDERSHEIMER</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>216-073162</b>		17. INFORMANT <b>HELEN S. GUNDERSHEIMER (AS ABOVE)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>trauma of bleeding</b> DUE TO <b>Ruptured Aortic Aneurysm</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. <b>Coronary artery</b> (b) <b>3 day</b> (c) <b>3 day</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>2/6</b> 19 <b>61</b> to <b>Feb. 9</b> 19 <b>61</b> that (I) (we) last saw the deceased alive on <b>Feb. 9</b> 19 <b>61</b> and that death occurred at <b>12:30 P.M.</b> causes and on the date stated above							
22a. SIGNATURE <b>Barry Rosenberg</b>				22b. DATE <b>Feb. 10 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Barry Rosenberg, M.D.</b>				22d. ADDRESS <b>1210 Chillum Manor Road, West Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>2/13/1961</b>		<b>MT. OLIVET CEM.</b>		<b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home Inc. Maryland</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

02222

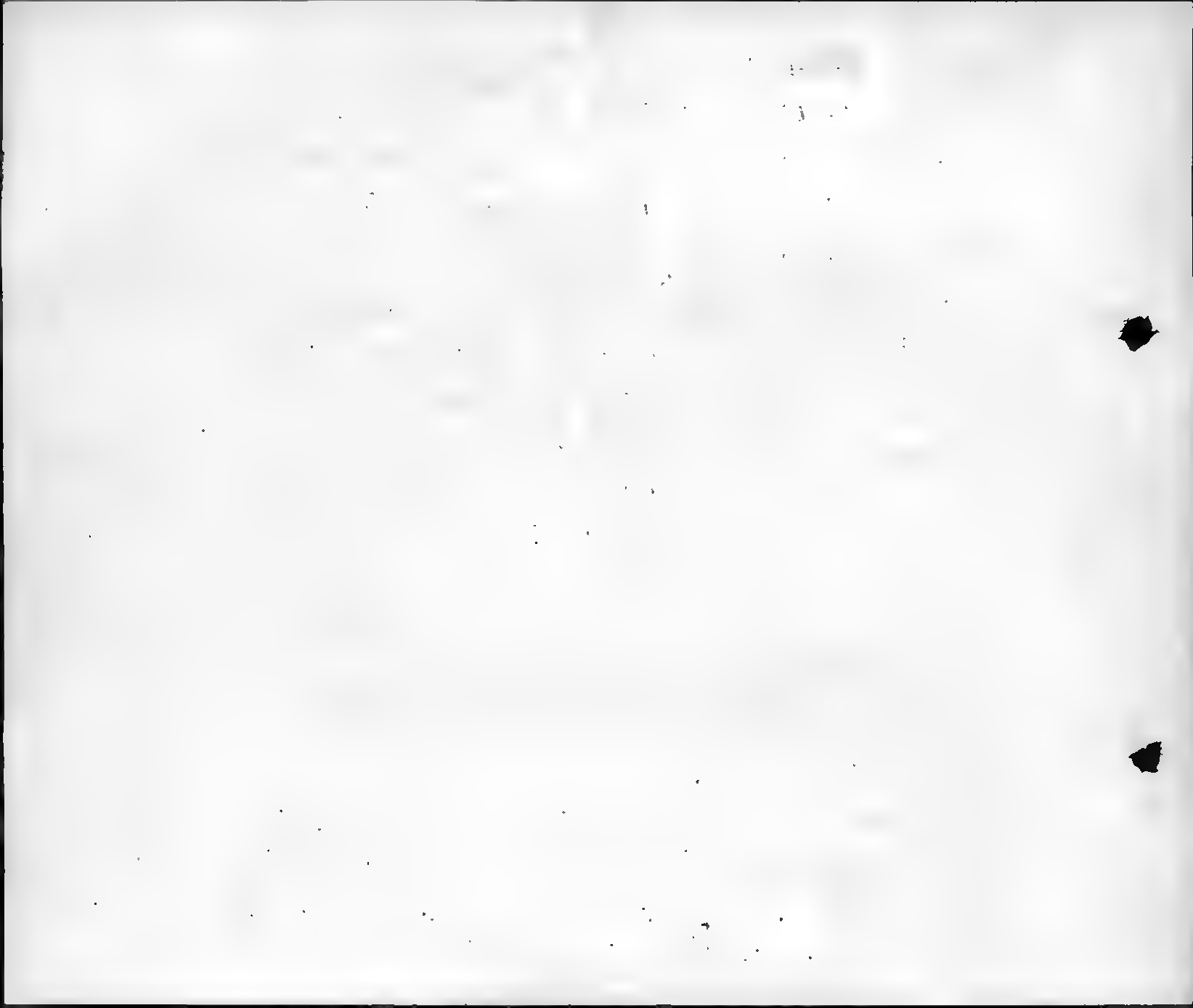
2245

Item 11-111m 0282 3/16/61

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PR. GEO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT RAINIER</b>		c. LENGTH OF STAY IN lb <b>6 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>4609 29th ST. APT 1.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT RAINIER, Md. 4</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ABEL HABERMAN</b>		4. DATE OF DEATH Month Day Year <b>FEB 7 1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 4, 1898</b>
9. AGE (In years last birthday) <b>62 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CLEANING</b>	
11. BIRTHPLACE (State or foreign country) <b>LONDON, ENGLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PHILIP HABERMAN</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Unterstein</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>578-09-1211</b>	
INFORMANT <b>ROTH HABERMAN</b>		Address <b>MT RAINIER, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>112 CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b> <b>2 YRS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>JAN 1, 1958</b> , to <b>FEB 7, 1961</b> , that I last saw the deceased alive on <b>FEB 7, 1961</b> , and that death occurred at <b>10:45 P.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Samuel J N Sugar</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>4300 KAYWOOD DRIVE 2/7/61</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL J N SUGAR</b>		<b>MT RAINIER, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Feb 11, 1961</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Stenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co Riverdale, Md.</b>		24a. RECEIVED BY REGISTRAR DATE <b>FEB 14 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. King</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 1 of 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

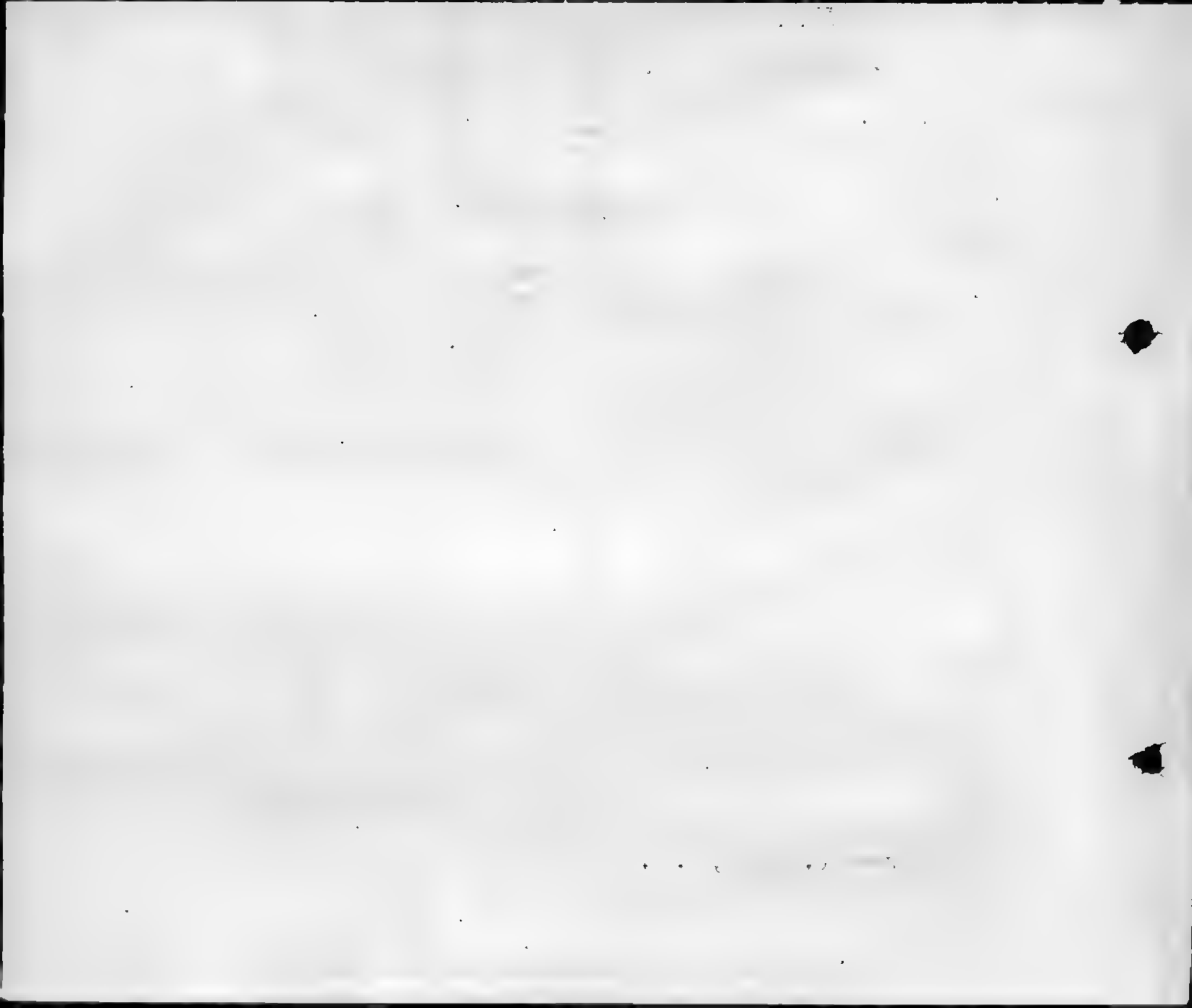
Reg. Dist. No. 2223

1. PLACE OF DEATH a. COUNTY <u>SOUTLAND MD.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTLAND NURSING HOME</u>		d. STREET ADDRESS <u>2924-WASH PH. S.E.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>HAGREEN</u>		4. DATE OF DEATH Month Day Year <u>February 18 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 28-75</u>
9. AGE (In years last birthday) <u>85</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES LANGLOS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FERN DELANEY (DAUGHTER)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u> <u>16 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 15, 1944</u> , to <u>Feb 10, 1961</u> , that I last saw the deceased alive on <u>Feb 18, 1961</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James C. Cawood</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2520 Pennsylvania Ave. S.E. 2/19/61</u>	
PHYSICIAN'S NAME (Type) <u>James C. Cawood, M.D.</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2/24/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, Wisconsin</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Q. Mattingly</u>		ADDRESS <u>131-11th St. S.E.</u>	
24a. RECEIVED BY REGISTRAR <u>FEB 21 '61</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fox</u>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



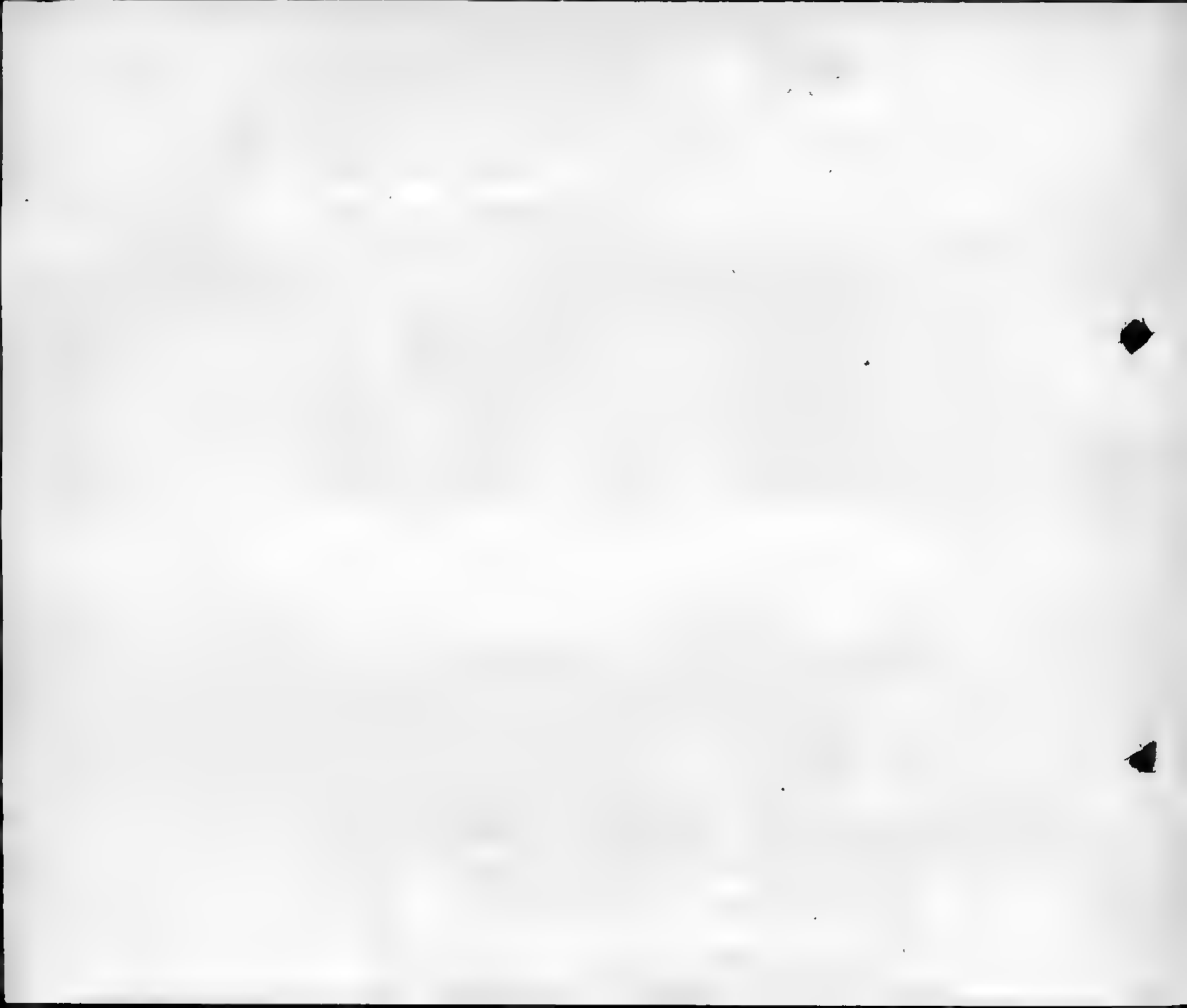
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

2247

12224

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LELAND Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Addie MAY HARDY</u>				4. DATE OF DEATH <u>Feb. 10 1961</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-5-76</u>	
9. AGE (In years last birthday) <u>85</u> yrs		10. UNDER 1 YEAR Months Days Hours		11. UNDER 24 HRS Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>F. Washington Musbaum</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Hosp Record</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4:20:30</u> DUE TO (b) <u>Arteriosclerotic Heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>undetermined</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 26 1961</u> to <u>Feb 10 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 10 1961</u> , and that death occurred at <u>4</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>L W Malin</u> M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/14/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glade Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>M. Walkersville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.C. Barton</u>				25a. REC'D BY REGISTRAR <u>W. Walkersville</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Howard</u>			
ADDRESS <u>Walkersville, Md.</u>				DATE <u>FEB 15 '61</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

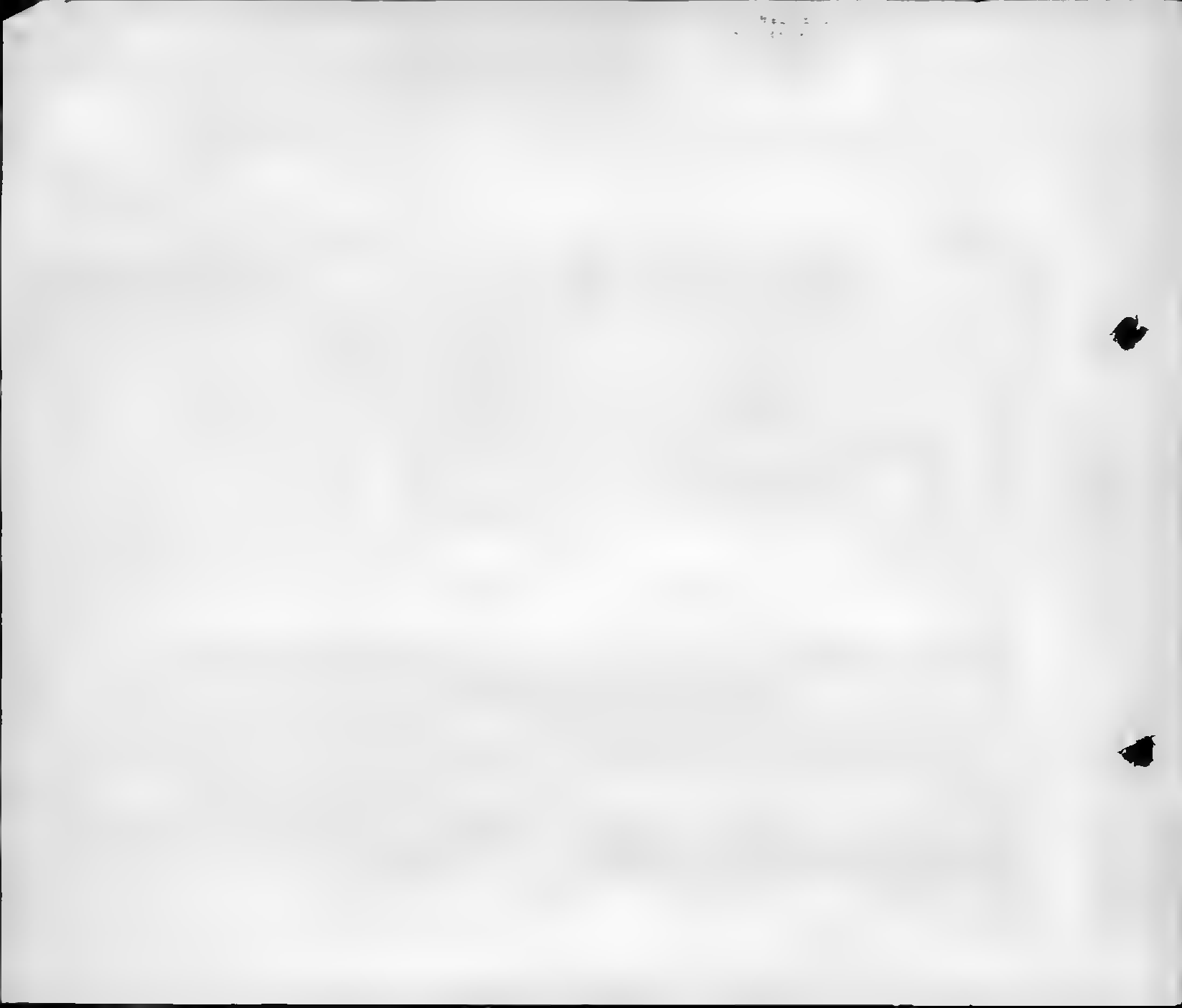
2248

## CERTIFICATE OF DEATH

Reg. Dist. No. 02225

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSTVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>524 HYATTSTVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>620-SHERIDAN STREET</u>				d. STREET ADDRESS <u>1620 SHERIDAN STREET</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>REBECCA BEATRICE HARRIS</u>				4. DATE OF DEATH Month Day Year <u>FEB 8 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 1, 1894</u>	9. AGE (In years last birthday) <u>66</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>MORRIS ROSENBLUM</u>				14. MOTHER'S MAIDEN NAME <u>ANNA FRIEDMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>083-01-28108</u>		17. INFORMANT <u>DAVID HARRIS</u>		Address <u>HYATTSTVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEART FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u> <u>3 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month <u>19</u>	Day <u>19</u>	Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>MT RAINIER, MD</u>	(County) <u>MT RAINIER, MD</u>
21. I certify that I attended the deceased from <u>JAN 1, 1942</u> to <u>FEB 8, 1961</u> , that I last saw the deceased alive on <u>FEB 8, 1961</u> , and that death occurred at <u>4:24 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4300 KAYWOOD DRIVE</u> DATE SIGNED <u>2/8/61</u>							
ACTUAL SIGNATURE <u>Samuel J. N. Sugar</u>		MD <u>4300 KAYWOOD DRIVE</u>					
PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u>		<u>MT RAINIER, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-10-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		22d. LOCATION (City, town, or county) <u>FALLS CHURCH VA.</u>		(State) <u>VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY + SONS</u>				ADDRESS <u>3501-14th St. NW</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 14 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. K...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

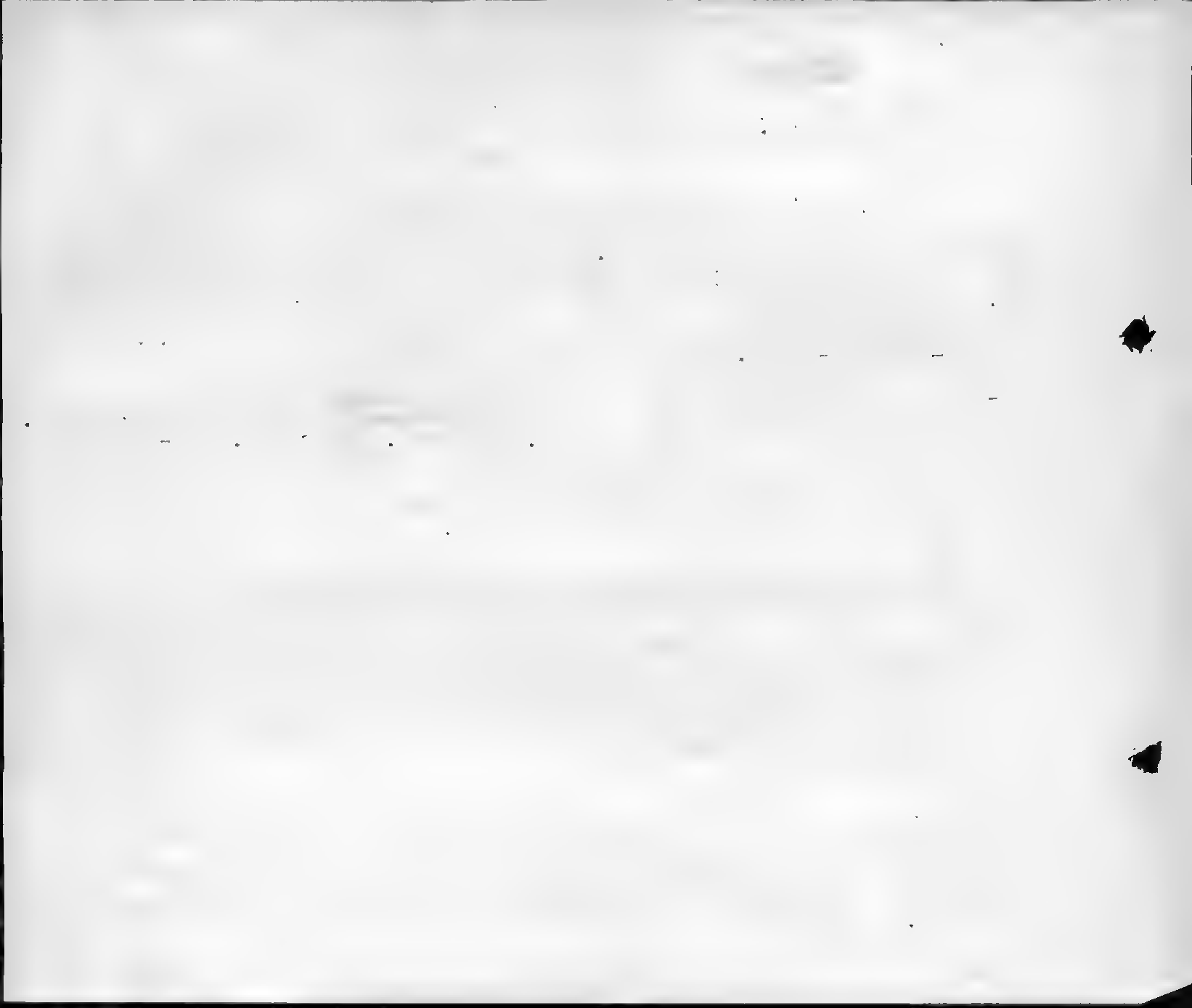
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

2249

02220

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmer Park</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>8210 Sherrill Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>Joan</b>	Middle <b>D.</b>	Last <b>Harvey</b>	4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>61</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/20/26</b>	9. AGE (In years, last birthday) <b>34</b> yrs	IF UNDER 1 YEAR Months <b>3</b> Days <b>11</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Food-Checker-A &amp; P.</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Food Business</b>		11. BIRTHPLACE (State or foreign country) <b>ENGLAND</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>WHEELER</b>			
14. MOTHER'S MAIDEN NAME <b>MAUD WHEELER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO				17. INFORMANT (Husband) <b>Mr. George W. Harvey, Jr.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO <b>Inlet of stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Care of the family</b> DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/11</b> <b>61</b> to <b>2/13</b> <b>61</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> <b>1961</b> , and that death occurred at <b>7:40</b> <b>PM</b> , from the causes and on the date stated above							
22a. SIGNATURE <b>Dayton O Watkins</b>		M. D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>2-14-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>DAYTON O WATKINS</b>		22d. ADDRESS <b>6318 Annapolis Rd Bladensburg Md</b>					
23a. BURIAL, CREMATION OR REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/16/1961</b>		23c. NAME OF CEMETERY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry J. J. J. J.</b>		ADDRESS <b>1300-N. N. W. Wash. DC</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 16 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. J. J.</b>	

I





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02267

2250

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>54 B Crescent</b>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>H.</b> Last <b>Herbert</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-17-04</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>		IF UNDER 24 HRS. Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>			
10a. U.S.A. OCCUPATION (Give kind of work done during last of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.-9.</b>							
13. FATHER'S NAME <b>ERNEST HERBERT</b>				14. MOTHER'S MAIDEN NAME <b>Lillian HARRISON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>Wife</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Empyema left chest</b> DUE TO (b) <b>Broncho genic carcinoma</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April 1960</b> to <b>22 Feb 1961</b> that (I) <del>was</del> last saw the deceased alive on <b>22 Feb 1961</b> and that death occurred at <b>4:11 P.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>H. David Kerr, M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <b>23 Feb 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. David Kerr</b>				22d. ADDRESS			
23a. BURIAL OR CREMATION <b>2/25/61</b>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Langley Washington</b>		23d. LOCATION (City, town, or county) (State) <b>Prince George</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Matthews Funeral Home</b>				25a. RECEIVED BY REGISTRAR <b>151-11 St. SE</b>		25b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ERNEST HERBERT  
D.C.  
WILLIAM HARRISON  
D.C.

— 27261 *Staph. subopacus* *Conce. Stange*

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

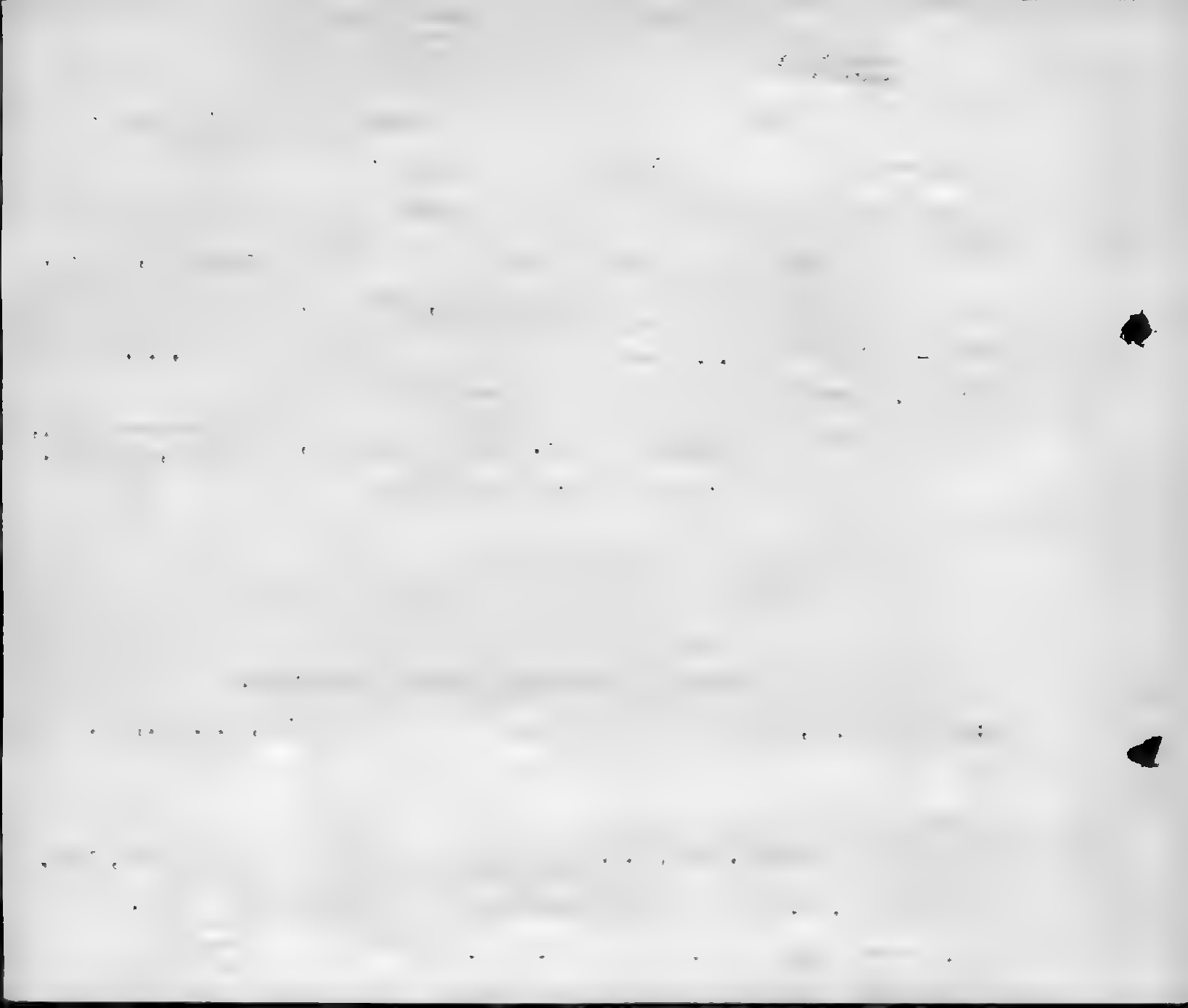
VS. 115ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2251 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
02223									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>					2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brandywine</b>					c. LENGTH OF STAY IN 1b <b>4 Years</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Rural</b>					d. STREET ADDRESS <b>Rural</b>				
3. NAME OF DECEASED (Type or print) <b>MADGE AUGUSTA HOLE</b>					4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 61</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 16, 1873</b>		9. AGE (In years last birthday) <b>87</b> IF UNDER 1 YEAR: Months <b>8</b> Days <b>7</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Retired</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Census</b>				
11. BIRTHPLACE (State or foreign country) <b>New York</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Charles S. Shoemaker</b>					14. MOTHER'S MAIDEN NAME <b>Angusta Cole</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>Unknown</b>				
17. INFORMANT <b>Mrs. Dorothy Stephenson,</b>					Address <b>#6 Petercooper Rd., New York, New York.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Universal Charring burns of Body</b> DUE TO <b>716.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Occupant of house that burned to the ground.</b>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>1:05</b> <b>Feb. 11, 19 61</b>					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>					20f. (City or town) (County) (State) <b>Brandywine, P.G.Cty., Md.</b>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>JAMES I. BOYD, M.D.</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>					22b. DATE THEREOF <b>2.13.61</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>					22d. LOCATION (City, town, or country) (State) <b>Washington D C.</b>				
23. FUNERAL DIRECTOR <b>Lee Funeral Home. 300.4th st N E.Wash.</b>					24a. REC'D BY REGISTRAR <b>FEB 14 '61</b>				
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>				

DATE SIGNED

February 11, 1961.



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2252

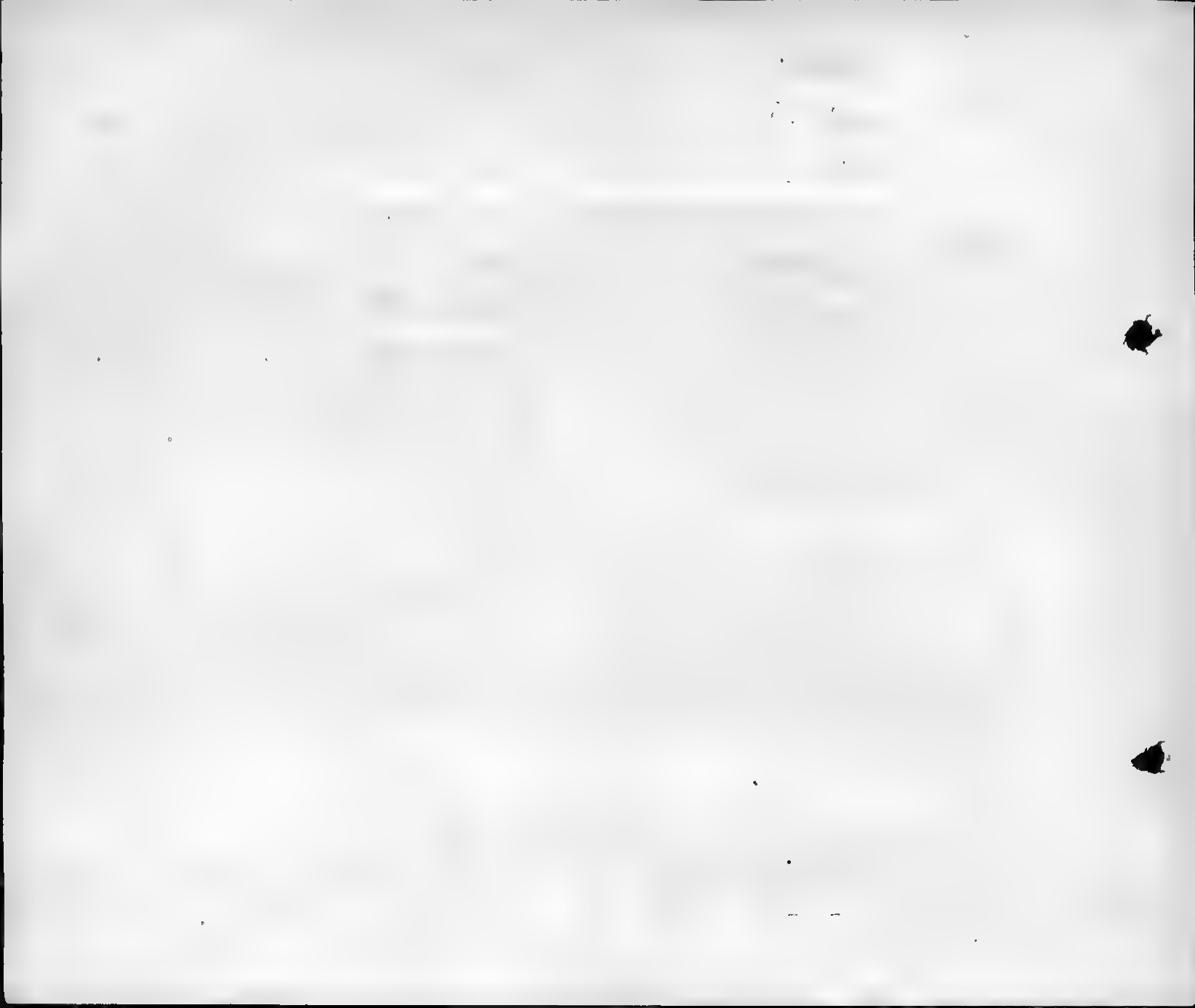
02230

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN TB <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Jackson</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>6</b> Year <b>19 61</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Black</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 April 1922</b>	
9. AGE (In years last birthday) <b>38</b> yrs.		10. IF UNDER 1 YEAR Months <b>38</b> Days <b>38</b> Hours <b>38</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None - Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Charles Hackley</b>				14. MOTHER'S MAIDEN NAME <b>Mable Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>George Jackson -Lanham, Md.</b>				Address			
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confluent Bronchopneumonia</b>						<b>48 hours</b>	
DUE TO <b>Gastro-intestinal hemorrhage</b>						<b>48 hours</b>	
(b) <b>Esophageal Varicosities</b>						<b>unknown</b>	
DUE TO <b>Cirrhosis of the Liver</b>						<b>unknown</b>	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>11,50 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon L. Gallin MD</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>Leon L. Gallin</b>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-11-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Ralston</b>				25a. REC'D BY REGISTRAR <b>26</b>			
25b. REGISTRAR'S SIGNATURE <b>William J. Ralston</b>				DATE <b>FEB 14 '61</b>			

2

1

26



2253

## CERTIFICATE OF DEATH

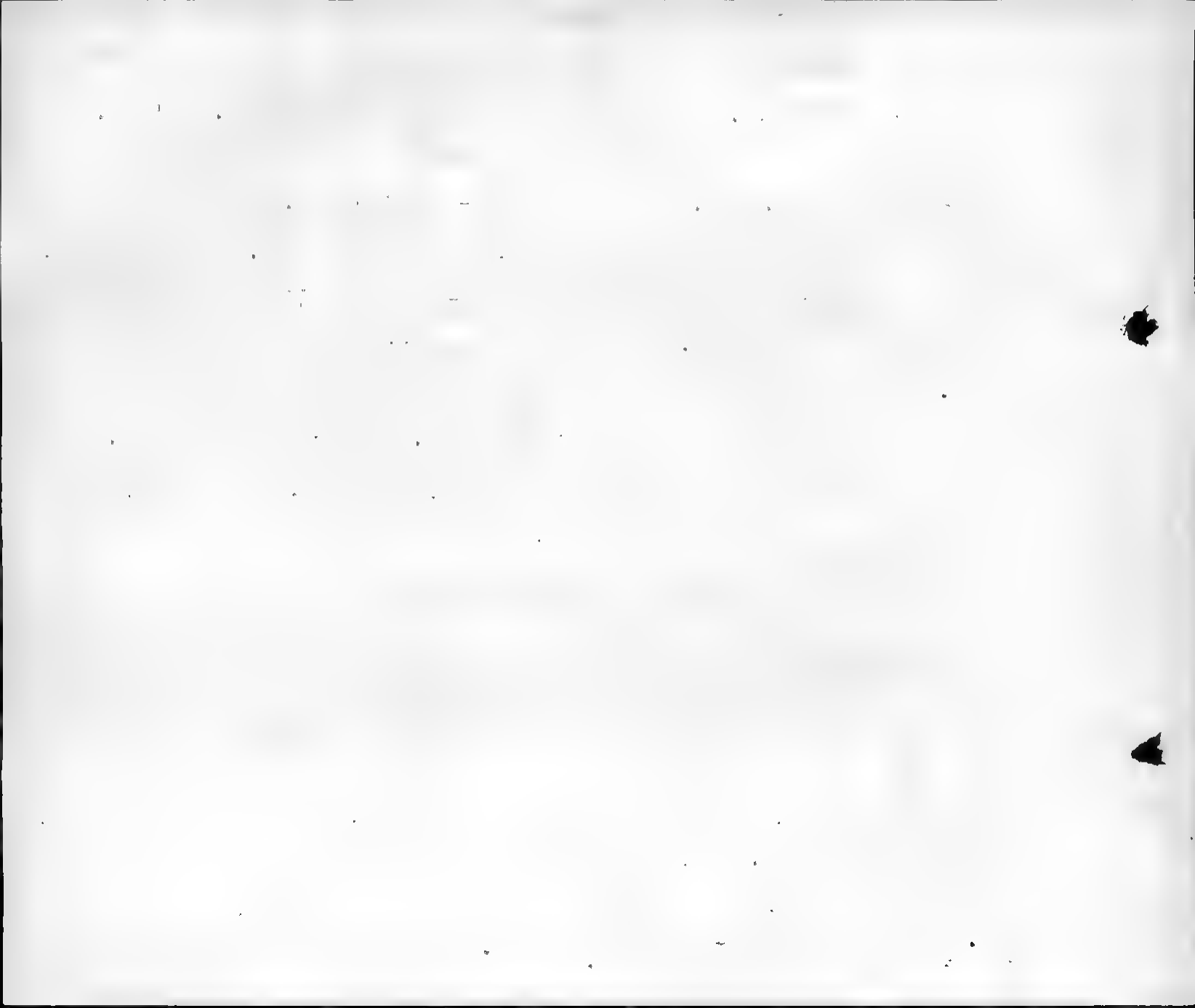
Reg. Dist. No.

02251

1. PLACE OF DEATH a. COUNTY Prince George's Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Park		c. LENGTH OF STAY IN 1b 20-Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5406- Shadyside Ave., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
NAME OF DECEASED (Type or print) ANNIE First BLANCH Middle JENKINS Last		4. DATE OF DEATH Feb. 28th 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29- 1885
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME D.J. Carson		14. MOTHER'S MAIDEN NAME Betty Dollar	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO INFORMANT Mrs. Evelyn M. Hollabaugh Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Hypertensive Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			INTERVAL BETWEEN ONSET AND DEATH 3 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 15, 1961, to Feb 28, 1961, that I last saw the deceased alive on Feb 28, 1961, and that death occurred at 6:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Benjamin S. Pecson M.D.		DATE SIGNED 2-28-61	
PHYSICIAN'S NAME (Type) Benjamin S. Pecson		ADDRESS (Street, city or town, state) 7078 Marlboro Pike Wash 28, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3rd March 61	22c. NAME OF CEMETERY OR CREMATORY Martha's Chapel Cemetery	22d. LOCATION (City, town or county) (State) Apex, N.C.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1661- Good Hope Road S.E. Washington, DC.		24a. REC'D BY REGISTRAR DATE MAR 2 61	24b. REGISTRAR'S SIGNATURE Charles E. Farris

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

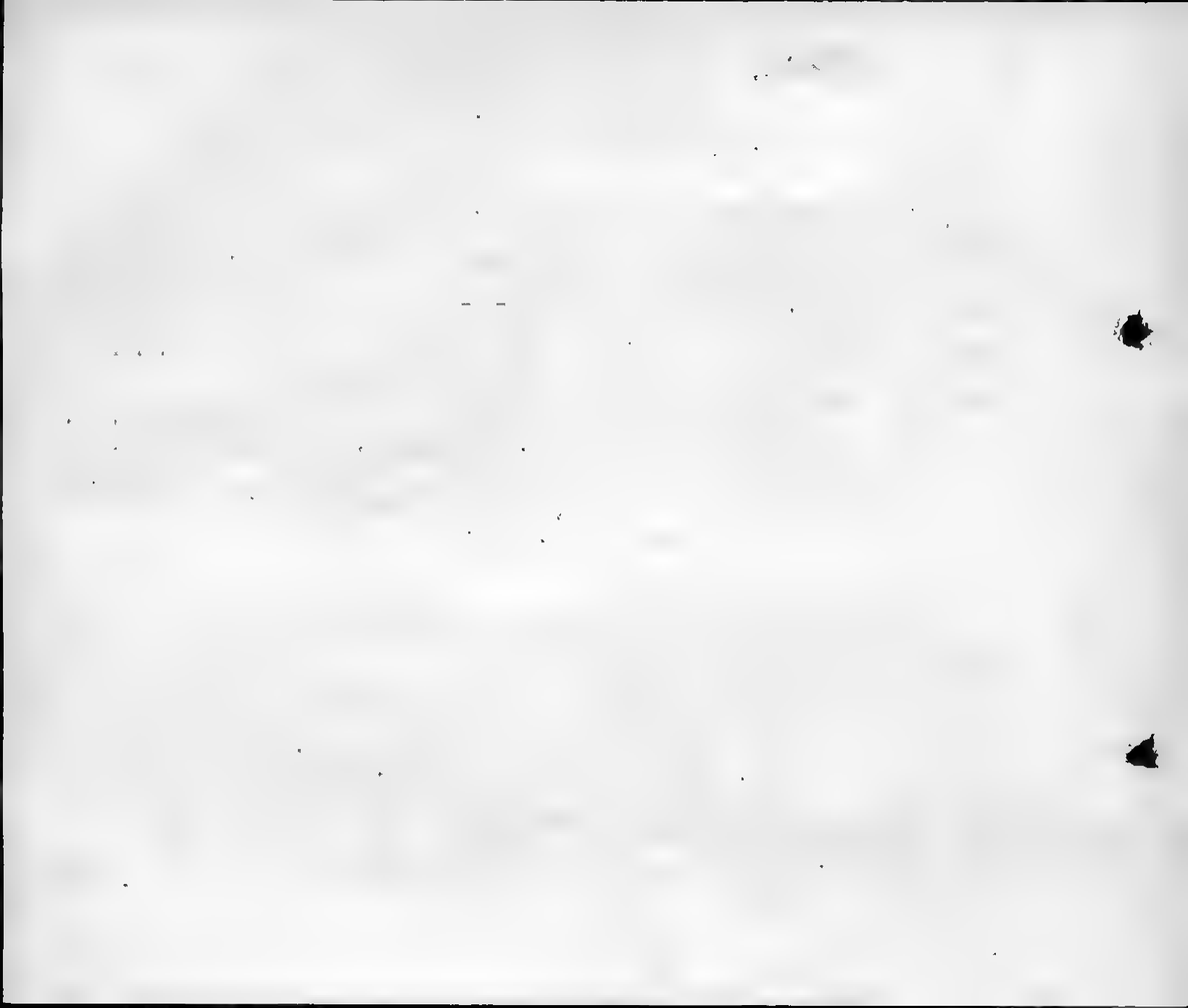
2254

2254

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

102206

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>29</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Va.</b> b. COUNTY <b>✓</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Columbia</b> d. STREET ADDRESS <b>Rt. #1 Box 163</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Arthur Jenkins</b>		4. DATE OF DEATH Month Day Year <b>Feb. 27 1961</b>	
5. SEX <b>Male</b>	6 COLOR OR RACE <b>Col.</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-17-87</b>
9. AGE (In years last birthday) <b>73</b>		10 IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Jenkins</b>		14. MOTHER'S MAIDEN NAME <b>Mollie ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>Hyattsville, Md.</b>	
17. INFORMANT <b>Mrs. Edith Arnett, 3215 Kenilworth Ave./</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>31X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>Jan. 30 1961</b> to <b>Feb. 27 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 27 1961</b> , and that death occurred at <b>2 Pm</b> , from the causes and on the date stated above.			
22a SIGNATURE <b>Thomas E. Edison</b>		22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <b>Dr. Edison</b>		22d ADDRESS <b>1015 Spring St. Silver Spring, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b DATE THEREOF <b>3-5-61</b>	
23c NAME OF CEMETERY OR CREMATORY <b>FAMILY CEMETERY</b>		23d LOCATION (City, town, or county) (State) <b>COLUMBIA, VIRGINIA</b>	
24 FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Plummer</b>		25a REC'D BY REGISTRAR <b>DATE MAR 3 '61</b>	
ADDRESS <b>3015-12 1st St NE Washington DC</b>		25b REGISTRAR'S SIGNATURE <b>C. J. S. K. K.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

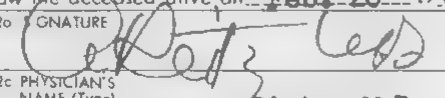
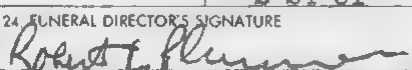
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

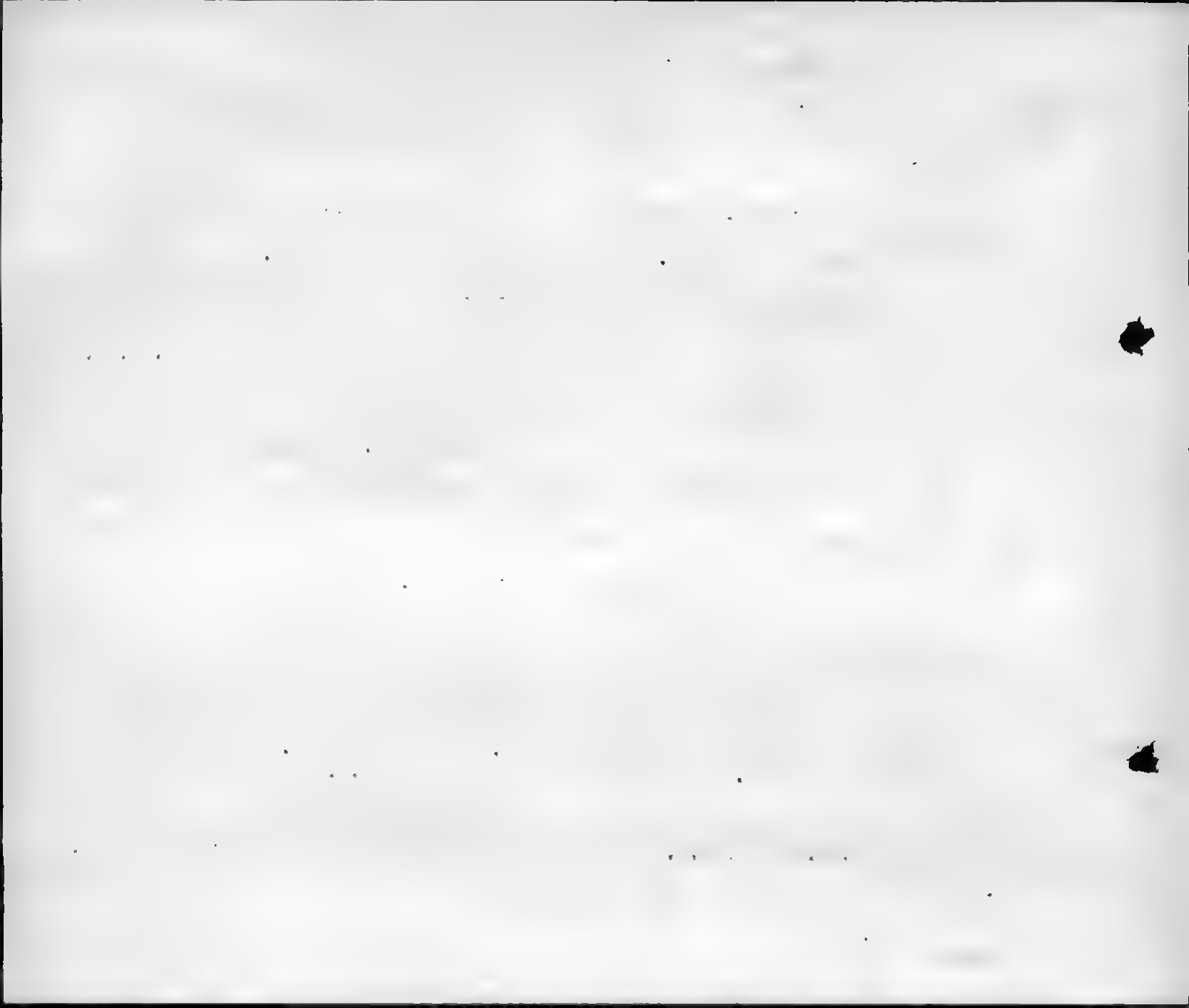
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

2255

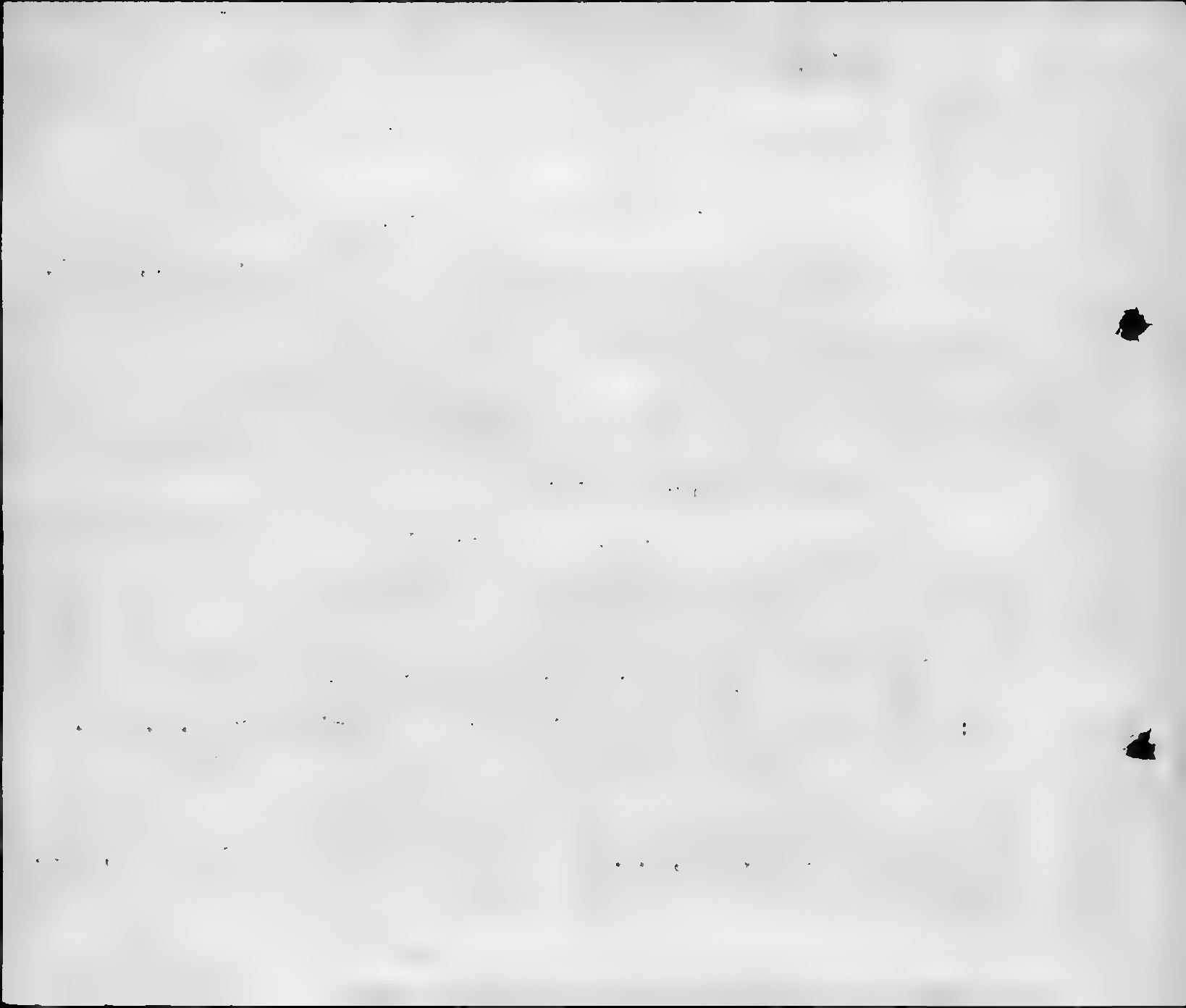
02253

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>24 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary A. Johnson</b>				4. DATE OF DEATH Month Day Year <b>Feb. 20 19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15- 1880</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Johnnie Jenkins</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Julia Gray 1715 Swann St. N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia and Congestive Heart Failure</b> 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral Stenosis, severe</b> DUE TO (c) <b>Rheumatic Heart Disease, old.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Substernal thyroid gland,</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o m p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 27</b> 19 <b>61</b> to <b>Feb. 20</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb. 20</b> 19 <b>61</b> , and that death occurred at <b>1:50 P.M.</b> the causes and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2-21-61</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. Dietz, M.D.</b>		22d. ADDRESS <b>4314 Gallatin St, Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-24-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Oxen Hill, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE 				25a. REC'D BY REGISTRAR <b>3015 12 Street, N.E.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Travis</b>	



Arthur J. Frazar

VS. A15ME  
5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2257

CERTIFICATE OF DEATH

02254

1. PLACE OF DEATH a. COUNTY <u>Pr. Geo. County</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Breendale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		d. STREET ADDRESS <u>14300 Emerson St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>J</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>6-19-12</u>		9. AGE (In years last birthday) <u>48</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Jones</u>		14. MOTHER'S MAIDEN NAME <u>Martha Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> 572.02 DUE TO (b) <u>Bowel resection - because of</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) <u>Ulcerative Colitis with Melena</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c): <u>Advanced Marfan's Strumpel's Disease &amp; advanced Kyphosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Coroner was notified</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Feb 12</u> 19 <u>61</u> to <u>Feb 20</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Feb 20</u> 19 <u>61</u> , and that death occurred at <u>2:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Theodore Zegaray, M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Theodore Zegaray, M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Transportation</u>		23b. DATE THEREOF <u>2/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Morris Funeral Home</u>		23d. LOCATION (City, town, or county) (State) <u>Johnson City, Tenn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 23 '61</u>	
ADDRESS <u>Hyattsville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Clara S. Kline</u>	

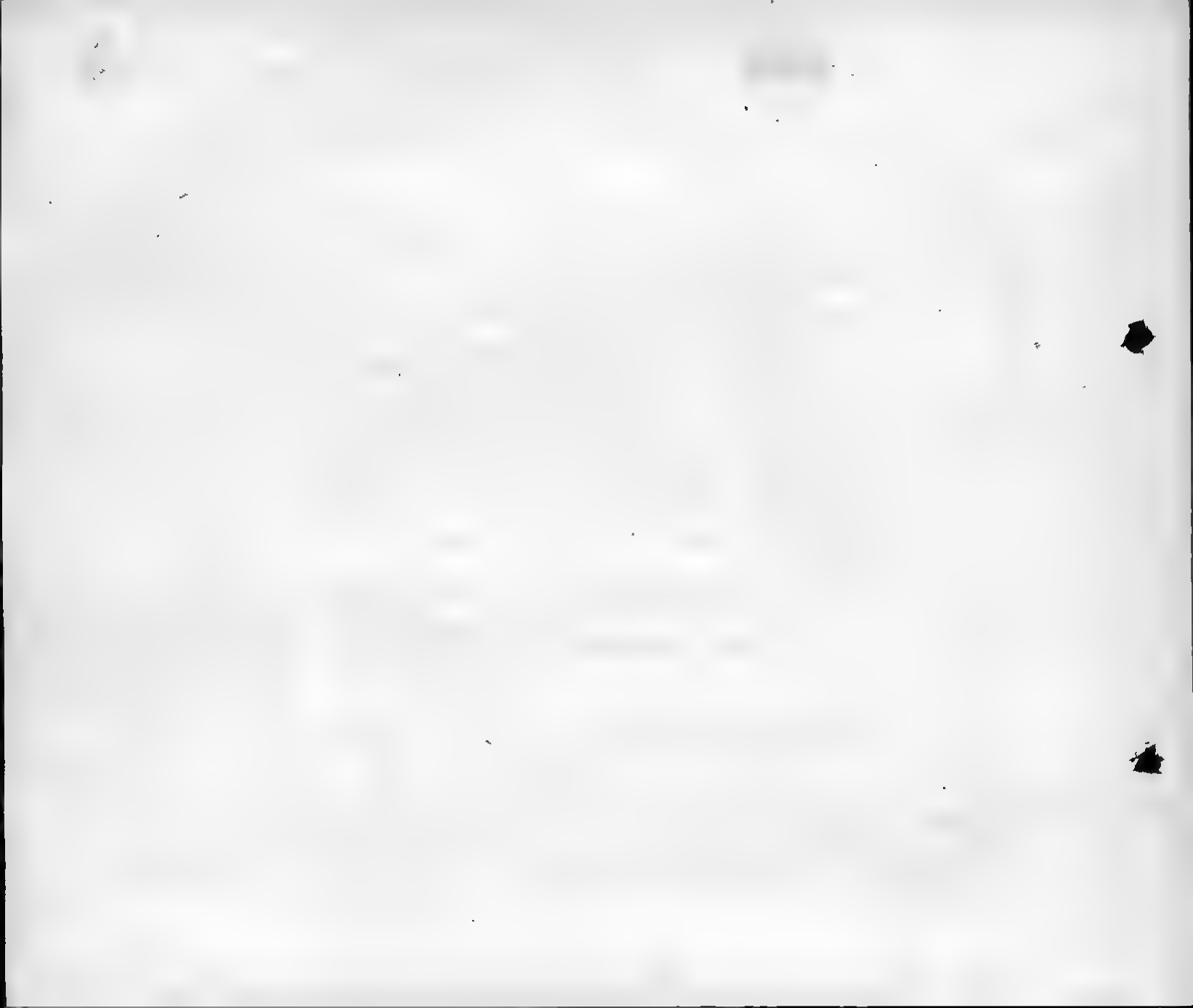




TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
2258  
M  
X  
122055  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4509-ELM Wood Road</u>				d. STREET ADDRESS <u>4509-ELM Wood Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDITH F Joyce</u>				4. DATE OF DEATH Month Day Year <u>Feb 23-nd 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9-1907</u>	9. AGE (in years lost birthday) <u>54</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thaddeus</u>		14. MOTHER'S MAIDEN NAME <u>Lipphard</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>William F. Joyce</u>		18. ADDRESS <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>260X</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Atherosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u> <u>10 yr.</u> <u>12 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>Feb 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 16 1961</u> , and that death occurred at <u>6AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Frank L. Weaver, Jr.</u>				22b. DATE SIGNED <u>2-23-61</u>		22c. PHYSICIAN'S NAME (Type) <u>FRANK L. WEAVER, JR., M.D.</u>	
22d. ADDRESS <u>Laurel, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Feb 25-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		23d. LOCATION (City, town, or county) (State) <u>Southland Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Seminora Brothers</u>				25a. REC'D BY REGISTRAR <u>1661 good Hope Rd</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>	
25c. DATE <u>FEB 24 '61</u>				25d. REGISTRAR'S SIGNATURE <u>Arthur S. Krum</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

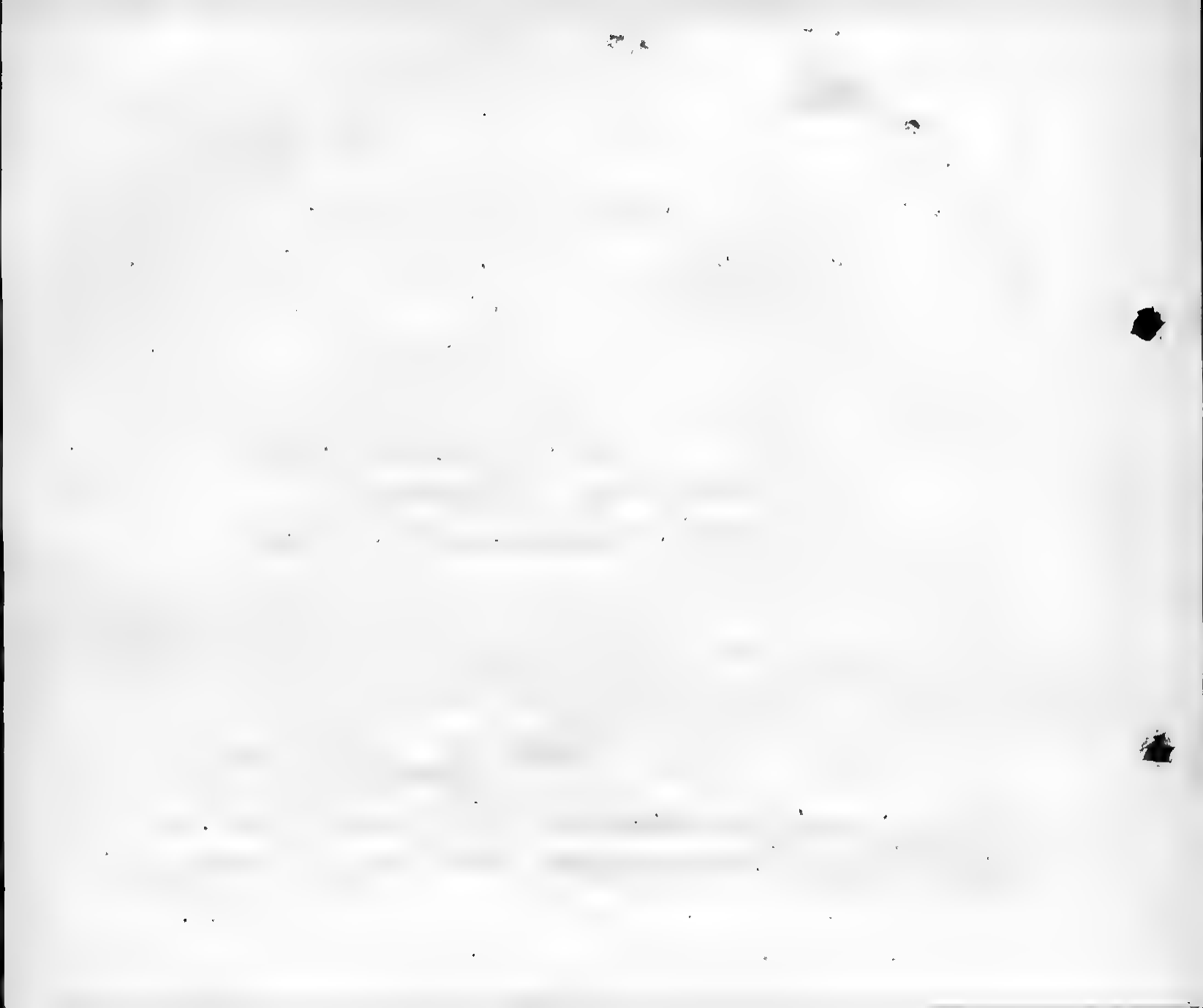
Items 2, 14 Film G280 2-6-61 et

## CERTIFICATE OF DEATH

Reg. Dist. No. **022311**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;">2259</span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> Washington d. STREET ADDRESS <b>3043-P-St., N.W.</b> <b>1727 VASALLA ROAD</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Catherine C Kelly</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>1</b> Year <b>1961</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Oct. 10, 1870</b>	
<b>9. AGE</b> (In years last birthday) <b>90</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Ireland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Michael Conroy</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO</b> <b>None</b>		<b>INFORMANT</b> Address <b>V. Rev. Msgr. John E. Kelly</b> <b>Washington, DC</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4721</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>Oct 49</b> <b>to</b> <b>2/1</b> <b>1961</b> , that I last saw the deceased alive on <b>2/1</b> <b>1961</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <b>Joseph J. Wallace, M.D.</b>				<b>ADDRESS</b> (Street, city or town, state) <b>1830 K ST. N. W. WASH DC 2/1/61</b>			
<b>PHYSICIAN'S NAME (Type)</b> <b>JOSEPH J. WALLACE, M.D.</b>				<b>1830 K ST. N. W. WASH DC, D.C.</b>			
<b>22a. BURIAL, CREMATION REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>2-4-61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Sepulcher</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Rochester, N.Y.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>James T. Ryan, Inc.</b>				<b>ADDRESS</b> <b>317 Pa. Ave., SE DC</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 3 '61</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>C. J. King &amp; Kenna</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR NURSING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

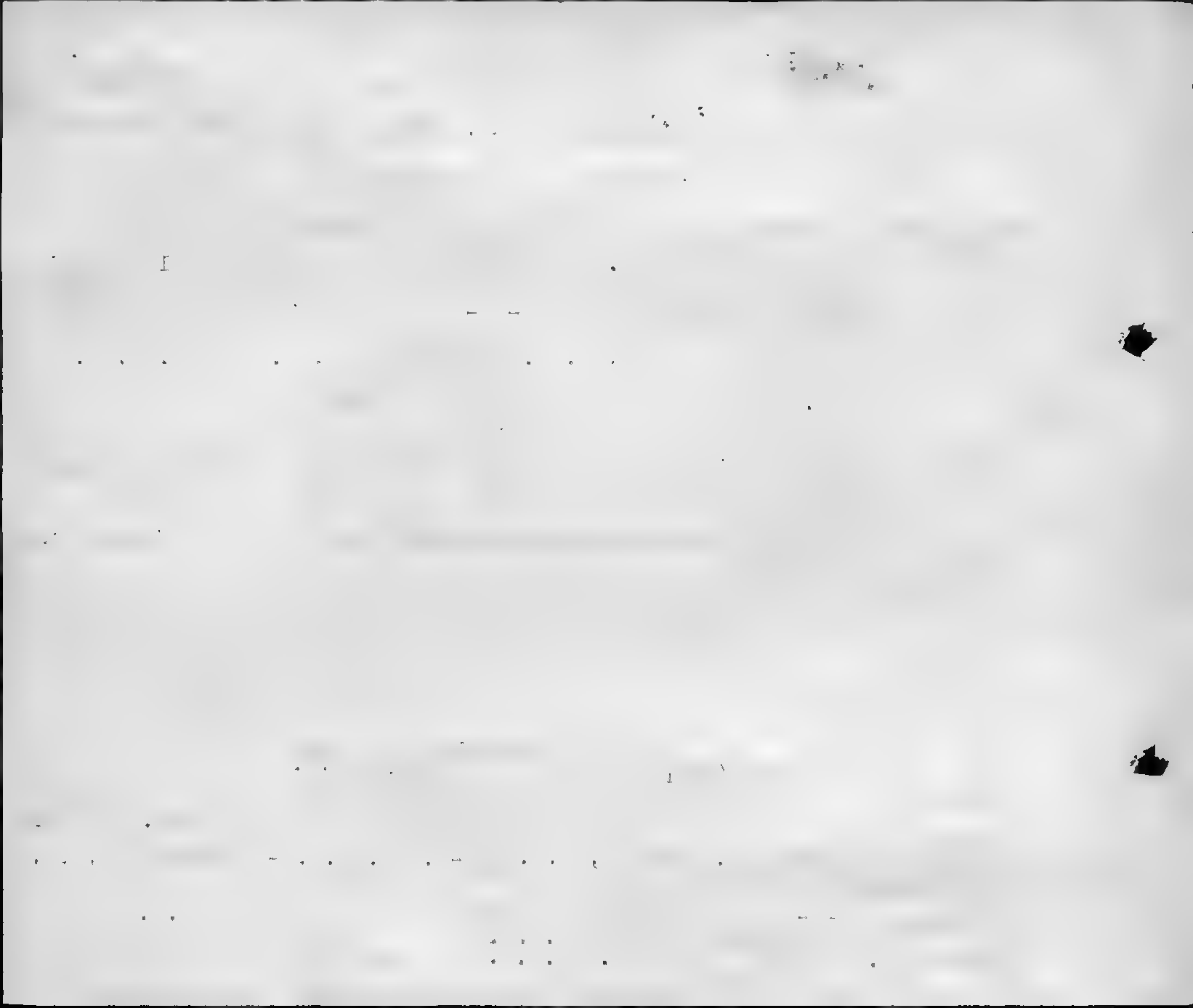
**CERTIFICATE OF DEATH**

**2260**

Item 2 Film G282 3/17/61 mh

02234

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> c. LENGTH OF STAY IN TB <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>D.C.</u> <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> <u>Washington</u> d. STREET ADDRESS <u>1205 New Hampshire Ave.</u> <u>4882/145411/ROAD N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>ROSE M. KEMP</u> First Middle Last		4. DATE OF DEATH <u>2</u> <u>1</u> <u>19 61</u> Month Day Year		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-29-78</u>			
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>1</u>		11. IF UNDER 24 HRS. Hours <u>19</u> Mins. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SOUTHERN, R. R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON D. C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>JOHN A. KEMP</u>		14. MOTHER'S MAIDEN NAME <u>ANN IRVIN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>718 15 6685</u>		17. INFORMANT <u>CARROLL MANOR RECORDS (SAME AS #2)</u> Address <u>AS #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Glomerulonephritis</u> (a), stating the underlying cause last, (c) <u>22 months</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5-12x</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3/30/1959</u> to <u>2/1/1961</u> , that (I) (we) last saw the deceased alive on <u>1/31/1961</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas F. Collins M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 1, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Collins, M.D.</u>		22d. ADDRESS <u>322-H. St. N.E. - Washington, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St OLIVET CEMETERY</u>			
23d. LOCATION (City, town or county) <u>WASHINGTON, D.C.</u>		23e. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Collins</u> ADDRESS <u>WASH. D.C.</u>		25a. REC'D BY REGISTRAR <u>Francis J. Collins</u>		25b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>			
25c. DATE <u>FEB 6 '61</u>		25d.					



2261

12208

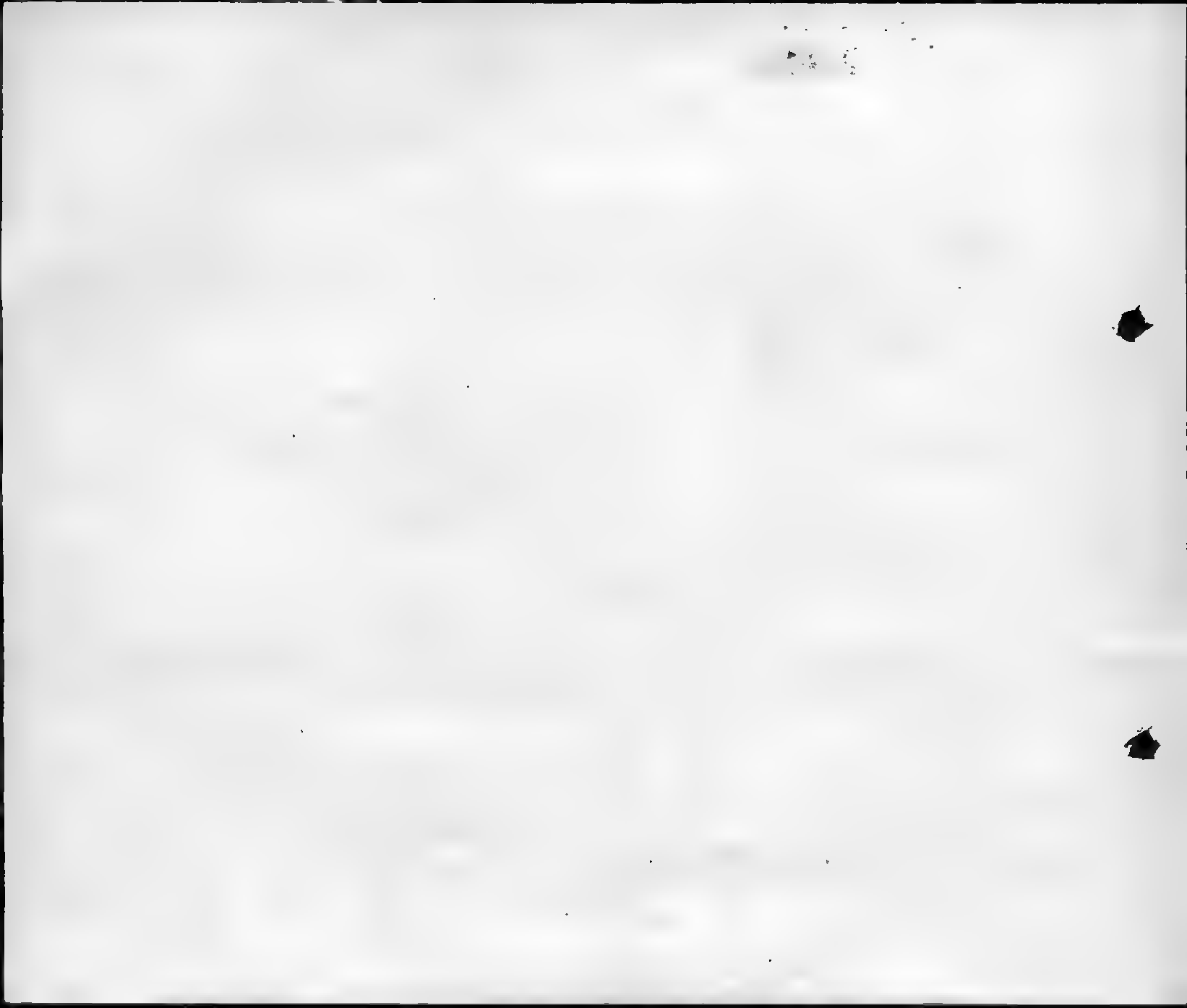
1

2261

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <i>Northridge</i>		c. LENGTH OF STAY IN 1b <i>49 North Woodbury</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>4510-24 Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Amelia</i> Middle <i>L</i> Last <i>Klein</i>		4. DATE OF DEATH Month <i>February</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>October 4, 1875</i>
9. AGE (In years last birthday) <i>85</i> yrs		10. IF UNDER 1 YEAR: Months <i>8</i> Days <i>5</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO <i>None</i>	
17. INFORMANT <i>Maryann Harvey</i>		Address <i>Route Laurel Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442x</i> DUE TO <i>cardiac arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>hypertension</i> DUE TO <i>soleriosis</i> (c) <i>u</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>o. m.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 1</i> 19 <i>61</i> , to <i>Feb 11</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Feb 10</i> 19 <i>61</i> and that death occurred at <i>10</i> PM, from the causes and on the date stated above			
22a. SIGNATURE <i>J. Chester Brady</i> M.D.		22b. DATE SIGNED <i>2/11/61</i>	
22c. PHYSICIAN'S NAME (Type) <i>J. Chester Brady</i>		22d. ADDRESS <i>35 My Ave Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/14/61</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>		23d. LOCATION (City, town, or county) (State) <i>Washington D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frank L. Sore Co</i>		25a. REC'D BY REGISTRAR <i>Feb 14 '61</i>	
ADDRESS <i>3605 14 St NW</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

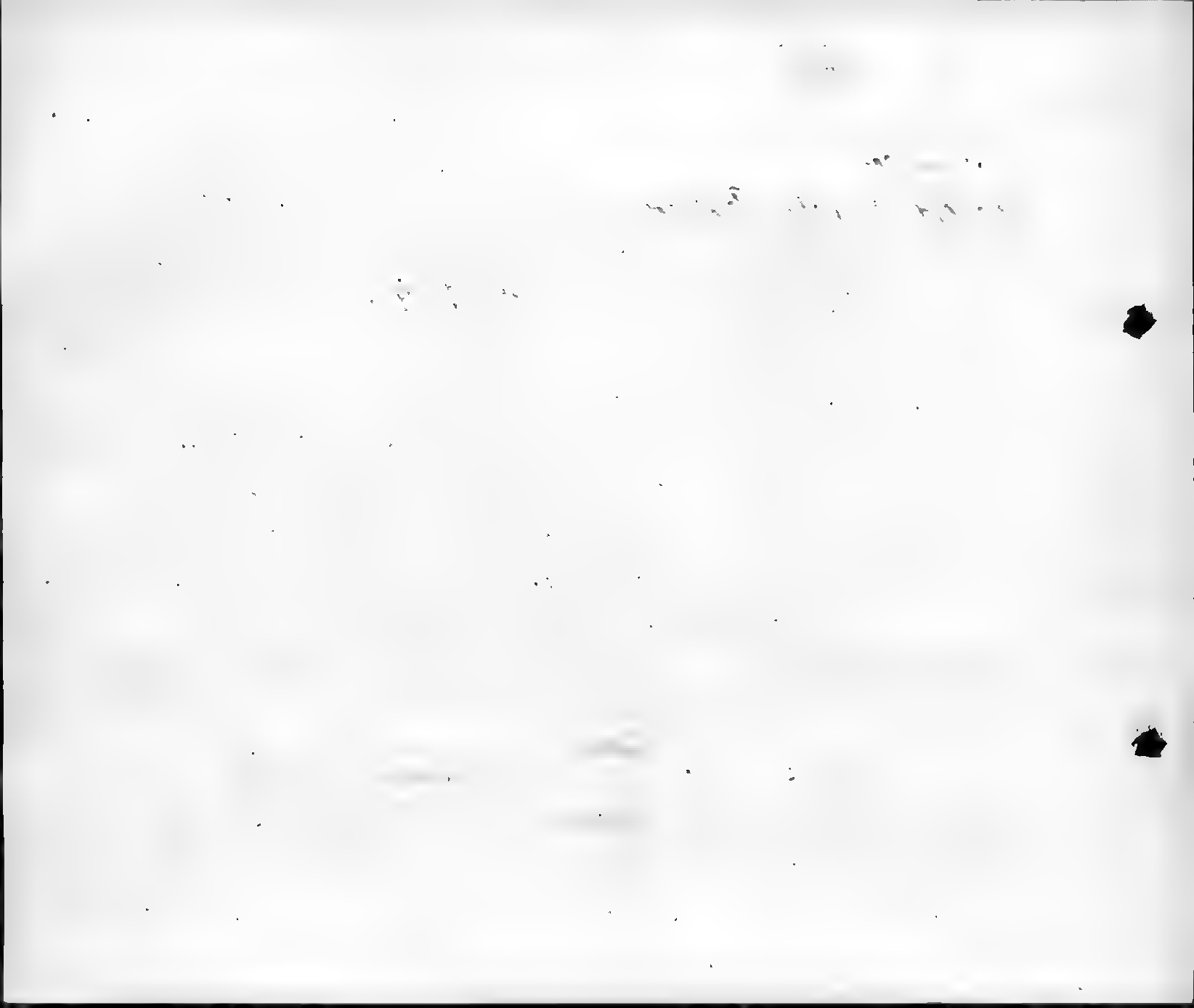
02233

2262

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>PR. Geo. Co.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. LENGTH OF STAY IN 1b <u>X CLINTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>So. Md. Hospital Center</u>		d. STREET ADDRESS <u>1 RFD # 3 - Box 632</u>	
3. NAME OF DECEASED (Type or print) <u>LENA</u> First <u>G.</u> Middle <u>K.</u> Last <u>KNIGHT</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1961</u>	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u># 28 1914</u>
9 AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>West. Virginia</u>	
11 BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Meadows</u>		14. MOTHER'S MAIDEN NAME <u>Julia A. Morris</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>Robert L. Knight</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420</u> DUE TO <u>CIRCULATORY COLLAPSE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY INSUFFICIENCY 1 HOUR</u> (c) <u>CARCINOMATOSIS GENERALIZED 3 WKS.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIVERTICULOSIS of INTESTINE</u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC. 20, 1960</u> to <u>FEB 7, 1961</u> that I last saw the deceased alive on <u>FEB 6, 1961</u> and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred R. Lapin</u> M.D.		ADDRESS (Street, city or town, state) <u>CLINTON, MD</u>	
PHYSICIAN'S NAME (Type) <u>Alfred R. Lapin</u>		DATE SIGNED	
22a BURIAL, CREMATION, REMOVAL (Specify)		22b DATE THEREOF	
22c NAME OF CEMETERY OR CREMATORY		22d LOCATION (City, town, or county) (State)	
23 FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
24a REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 8 '61</u>		<u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

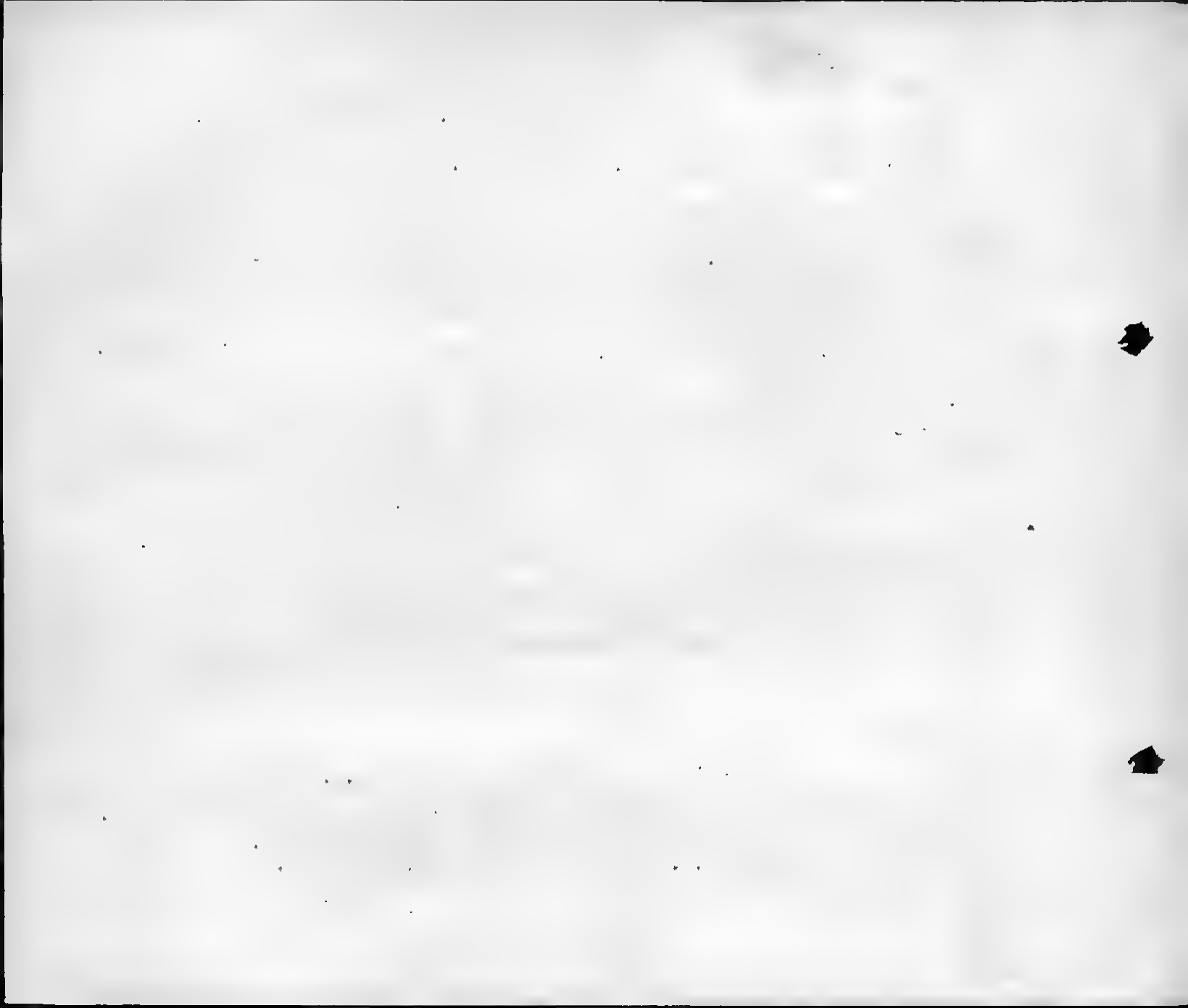
VR A15 (4)  
15M 9/59

2263

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02240

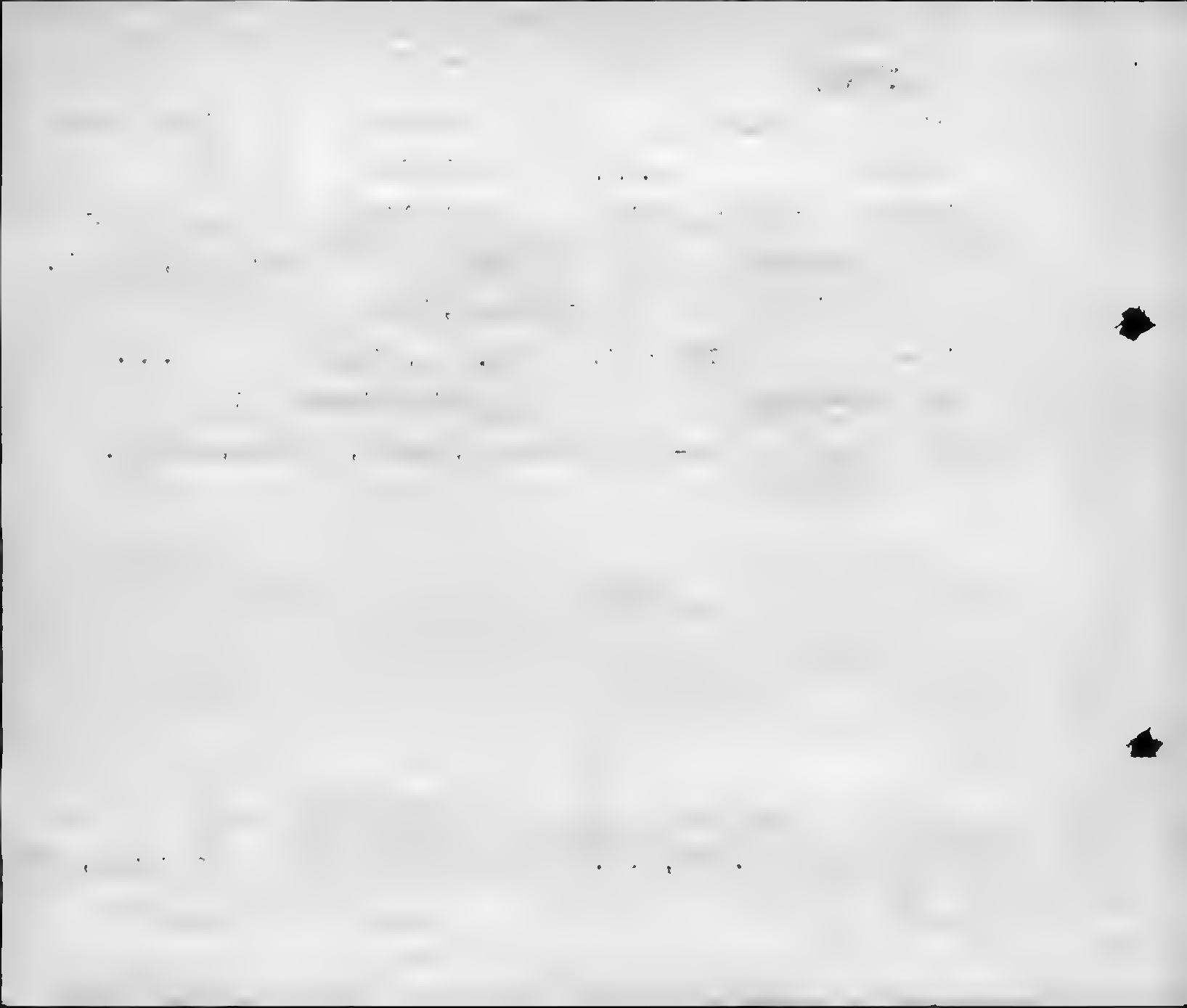
1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 5 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 64 E. Riverdale d. STREET ADDRESS 1 6006 Longfellow Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Milton A. Kyle		4. DATE OF DEATH Month Day Year 2-3 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-15 9. AGE (In years last birthday) 45 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY P.E.P.C. D.C.	11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HOWARD KYLE 14. MOTHER'S MAIDEN NAME PANSY CRAWFORD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> WORLD WAR II		16. SOCIAL SECURITY NO. 577-05-5960 17. INFORMANT MARGARET G. KYLE Address SAME AS #2	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 430 Myocardial Infarction DUE TO (b) Occlusion of Right Coronary Artery DUE TO (c) Coronary Atherosclerotic Ht. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5 hrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 hrs. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost the deceased on 2-3-61 19, and that death occurred on 1054 A.M. the causes and on the date stated above.			
22a. SIGNATURE Albert Roth		22b. ADDRESS 5510 Madison St. Riverdale, Md.	
22c. PHYSICIAN'S NAME (Type) Albert Roth, M.D.		22d. ADDRESS 5510 Madison St. Riverdale, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF FEB 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEM		23d. LOCATION (City, town or county) (State) SUTLAND, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Chambers Funeral Home		25a. REC'D BY REGISTRAR MD DATE FEB 9 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	



VS. A15ME  
5M 7/59

2264

Chlorine 4



1 ~~X~~  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2265 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02242											
1. PLACE OF DEATH a. COUNTY Prince George's						2. USUAL RESIDENCE (Where deceased lived, if first Union: Residence before admission) a. STATE Maryland b. COUNTY Prince George's					
b. CITY OR TOWN if outside corporate limits, write RURAL and give nearest town Accokeek						c. LENGTH OF STAY IN la 3 months X b. Accokeek					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						d. STREET ADDRESS 1 Route #1 Box 70					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 1 Box 70						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie Leak						4. DATE OF DEATH 2 25 19 61					
5. SEX Female						6. COLOR OR RACE Colored					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 4-17-92					
9. AGE (In years last birthday) 68 yrs.						10. UNDER 1 YEAR Months Days Hours Min.					
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						12. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) South Carolina					
13. FATHER'S NAME Waver Thomas						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 17. INFORMANT Hassie Leak, same as #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4-12X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a						Interval BETWEEN ONSET AND DEATH Acute Congestive heart failure Cardiovascular renal disease					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
SIGNATURE James I. Boyd						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) James I. Boyd						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL						22b. DATE THEREOF 3-3-61					
22c. NAME OF CEMETERY OR CREMATORY CARVER MEM. CEM.						22d. LOCATION (City, town, or country, (State)) BELTSVILLE, MD.					
23. FUNERAL DIRECTOR Robert L. Plummer						24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE					
Address 301-12th St NE Washington 17, D.C.						DATE MAR 3 '61 Arthur L. Kline					

(M)

(I)





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2266

02243

<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGE</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6009 LAFAYETTE AVE</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> d. STREET ADDRESS <u>6009 LAFAYETTE AVE</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CLARA M. LIPPERT</u>		<b>4. DATE OF DEATH</b> Month <u>FEB.</u> Day <u>11.</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>JUNE 27, 1887</u>		<b>9. AGE</b> (In years last birthday) <u>73</u>		<b>10. IF UNDER 1 YEAR</b> Months <u>7</u> Days <u>13</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>NEW YORK</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>RHINEHART COOK</u>					
<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY GOODEN</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>					
<b>16. SOCIAL SECURITY NO.</b> <u>NO</u>		<b>17. INFORMANT</b> Address <u>6009 LAFAYETTE AVE</u> <u>RAYMOND LIPPERT RIVERDALE MD.</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> (b) <u>Cardio Vascular Disease</u> (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER!)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JUN 11 1957</u> <b>to</b> <u>JUL 11 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>JUL 11 1961</u> , <b>and that death occurred at</b> <u>12:14 PM</u> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Robert R. Seltzer</u> M.D.		<b>22b. ADDRESS</b> <u>1222 Monroe St NE</u>		<b>22c. PHYSICIAN'S NAME</b> (Type)			
<b>22d. DATE SIGNED</b>		<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-15-61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>87. Bonaventure Cent. Allegheny N.Y.</u>			
<b>23d. LOCATION</b> (City, town or county)		<b>23e. (State)</b>		<b>23f. (Country)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. W. Lee</u>		<b>24a. ADDRESS</b> <u>Washington DC</u>		<b>25a. REC'D BY REGISTRAR</b>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hines</u>		<b>25c. DATE</b> <u>FEB 14 1961</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1942

1942

1942

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2267

## CERTIFICATE OF DEATH

Reg. Dist. No. 112244

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Hyattsville (Green Meadows)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6511 20th Ave.</u>		d. STREET ADDRESS <u>16511 20th Avenue</u>	

3. NAME OF DECEASED (Type or print) <u>FANNIE C. LIVAUDAIS</u>		4. DATE OF DEATH <u>Feb</u> <u>12</u> <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1864</u>
		9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Music</u>	11. BIRTHPLACE (State or foreign country) <u>Columbia, Louisiana</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	--

13. FATHER'S NAME <u>Wade H. Hough</u>	14. MOTHER'S MAIDEN NAME <u>Catherine Hill</u>
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT <u>Mrs. Undine L. Fitzgerald (same as #2)</u>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>generally &amp; extensive lesions</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>24 hrs.</u>
--	--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1942 19    to 2/16 1961, that I last saw the deceased alive on 2/11 1961, and that death occurred at 11:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE James T. Burns M.D. 9/15-19/76 St. Paul DATE SIGNED 2/12/61

PHYSICIAN'S NAME (Type) JAMES T. BURNS, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 16, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Monroe, Louisiana</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Watson</u>		24a. REC'D BY REGISTRAR <u>254 Carroll St NW D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>  </u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2268

02240

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				e. STREET ADDRESS <b>2216 Kearny Street N.E.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>R.</b> Last <b>MacDonald</b>				4. DATE OF DEATH Month <b>2-14-</b> Day Year <b>19 61</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02</b> <b>7-17-03</b>	9. AGE (In years last birthday) <b>58</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WRITER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FREELANCE</b>		11. BIRTHPLACE (State or foreign country) <b>SCOTLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PETER MacDonald</b>				14. MOTHER'S MAIDEN NAME <b>ANNIE MAC-RITCHIE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>095-07-6176</b>		17. INFORMANT Address <b>EDNA MacDonald 2216 KEARNY ST. NE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Acute pul empy hem</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarction</b> DUE TO <b>Arteriosclerosis with obs.</b> (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>6 years</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> , 19 to <b>Feb 14</b> , 1961, that (I) (we) last saw the deceased alive on <b>Feb 14</b> , 1961, and that death occurred <b>10:25 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Leon R. Levitsky M.D.</b>				22b. ADDRESS <b>3408 Rhode Island Ave. Mt Rainier Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Leon R. Levitsky, M.D.</b>				22d. ADDRESS <b>3408 Rhode Island Ave. Mt Rainier Md.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2/17/61</b>		<b>Fort Lincoln</b>		<b>3301 Bladenburg N.E. Washington</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Epamphero</b>				25a. REC'D BY REGISTRAR <b>5801 Cleveland Rd. Riverdale Md</b>		25b. REGISTRAR'S SIGNATURE <b>Carlton S. K...</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

**2269**

**02240**

1. PLACE OF DEATH, a. COUNTY <i>Prince George</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Riverdale</i>		c. LENGTH OF STAY IN 1b <i>Unknown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Eugene Leland Memorial Hospital</i>				d. STREET ADDRESS <i>11012 Montgomery Rd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Josephine</i> Middle <i>M.</i> Last <i>Maher</i>		4. DATE OF DEATH Month <i>Feb.</i> Day <i>17</i> Year <i>1961</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown 1871</i>		9. AGE (In years last birthday) <i>90</i> yrs.
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Maher</i>		14. MOTHER'S MAIDEN NAME <i>Anne Fitzpatrick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>✓</i>		17. INFORMANT Name <i>Mrs Borck</i> Address <i>11012 Montgomery Rd, Beltsville Md.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Anterior wall myocardial infarction</i> (c) <i>None</i>				INTERVAL BETWEEN ONSET AND DEATH <i>None</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senility - Old Age</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Beltsville</i>	(County) <i>Prince George</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>2-8</i> 19 <i>61</i> to <i>2-17</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>2-17</i> 19 <i>61</i> , and that death occurred at <i>11 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>D.R. Purdie</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>2-17-61</i>	
22c. PHYSICIAN'S NAME (Type) <i>D. R. Purdie</i>		22d. ADDRESS <i>90 Leland Mem Hosp Riverdale Md.</i>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2/21/61</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Augustine Cem. Elbridge Md.</i>	23d. LOCATION (City, town, or county) <i>Elbridge Md.</i>	(State) <i>Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Cowan</i>		25a. REC'D BY REGISTRAR <i>✓</i>	25b. REGISTRAR'S SIGNATURE <i>Charles S. Harris</i>	
DATE <i>FEB 20 '61</i>				

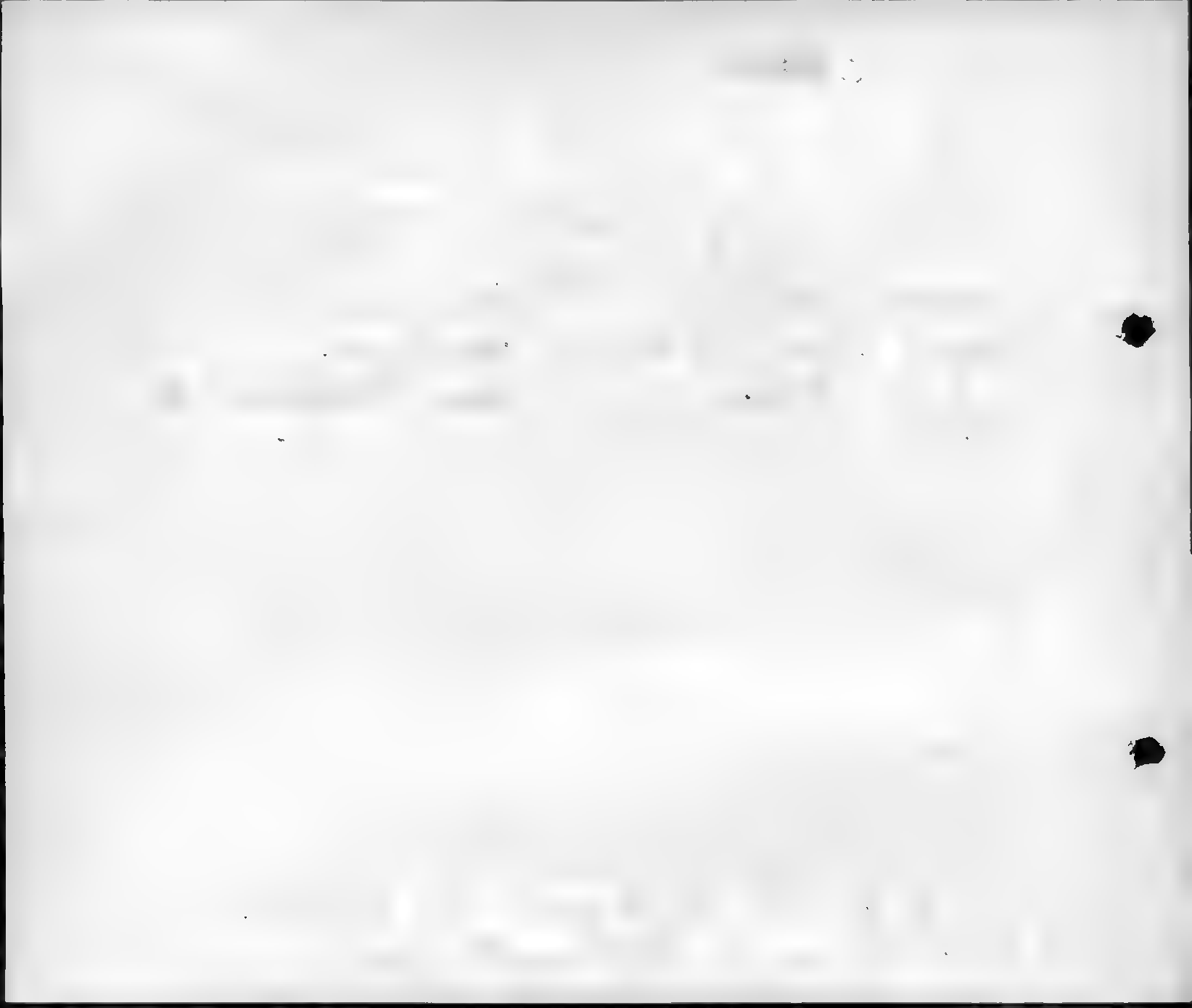
*016*

*I*

*1*

*M*

*1*





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

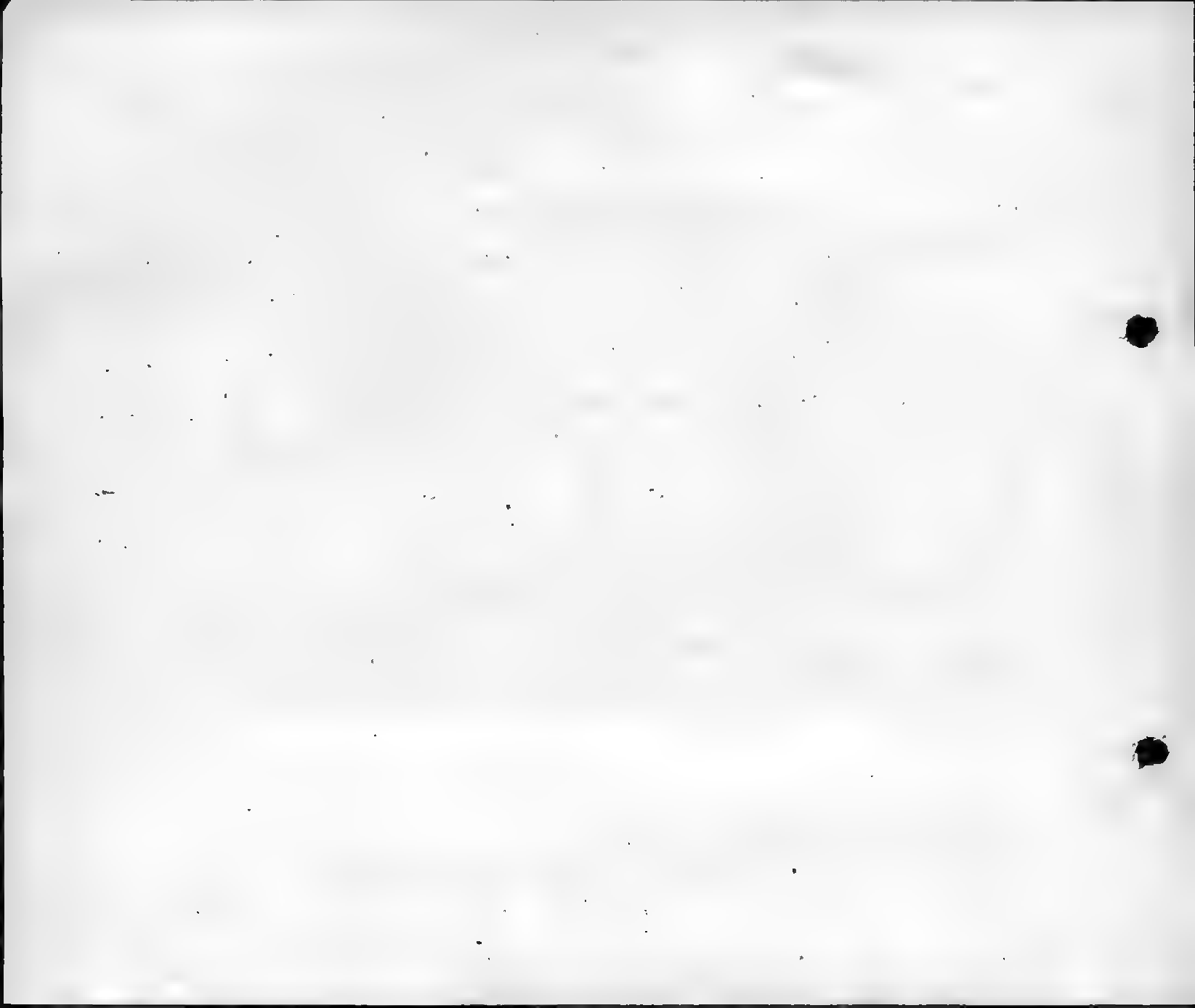
Item 12 Film 6231 2-20-61 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 2247

2270

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier 47	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 4100-30 <sup>th</sup> Street	
3. NAME OF DECEASED (Type or print) Hans G. Matthesius		4. DATE DEATH Feb. 7 <sup>th</sup> , 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Telephone	
11. BIRTHPLACE (State or foreign country) Leipzig, Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Matthesius		14. MOTHER'S MAIDEN NAME Johanna — Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. INFORMANT Ethel A. Matthesius Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4204 DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiovascular disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1960, to Feb 7, 1961, that I last saw the deceased alive on Feb 6, 1961, and that death occurred at 10:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2716 Kirkwood Place. DATE SIGNED			
ACTUAL SIGNATURE Earl W. Straff M.D.		22a. LOCATION (City, town, or county) (State) 2716 Kirkwood Place Md.	
PHYSICIAN'S NAME (Type) EARL W. STRAFF, M.D.		22b. REGISTRAR'S SIGNATURE Arthur E. Hines	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/10/61	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.		24a. REC'D BY REGISTRAR DATE FEB 14 1961	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2271

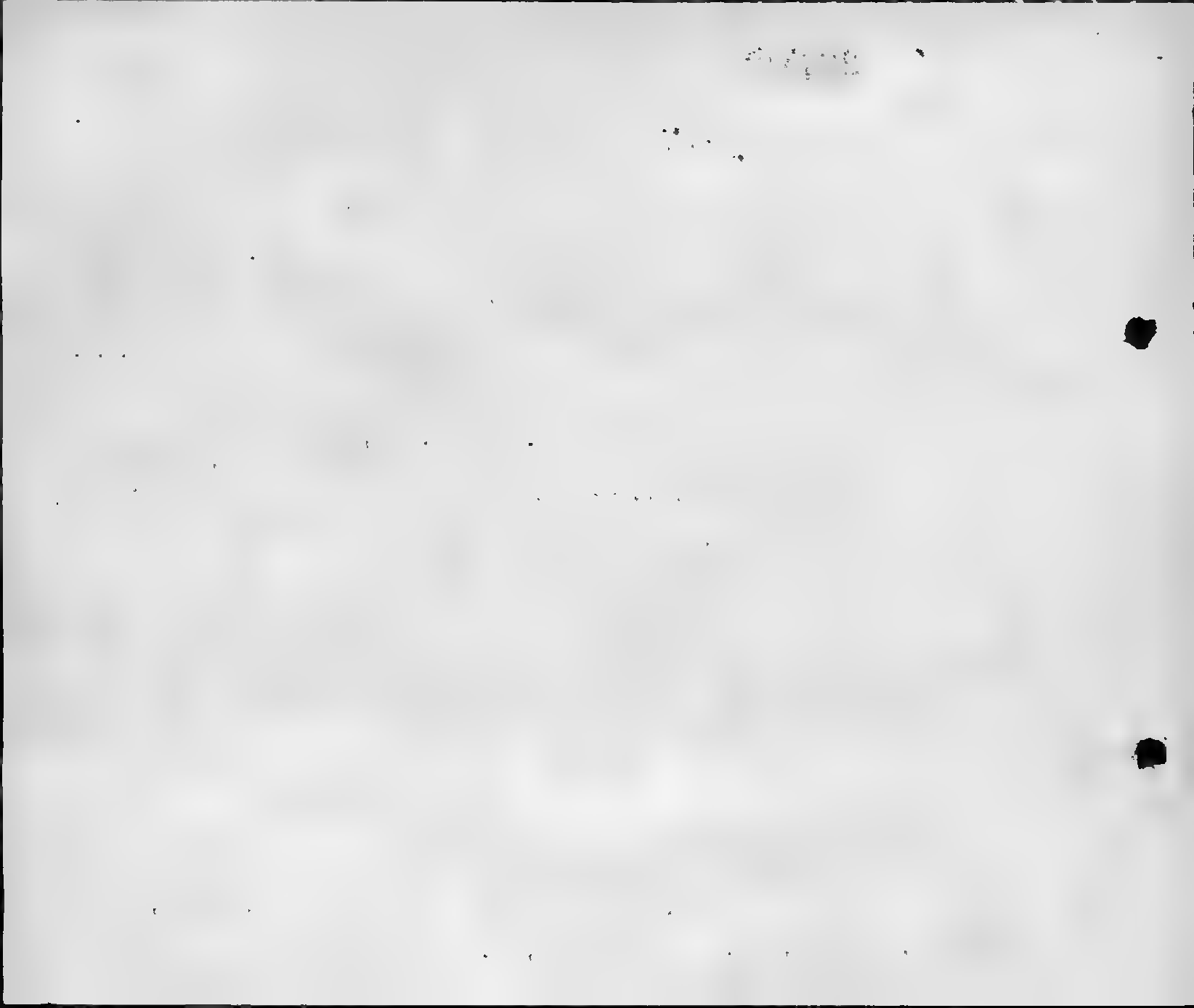
## CERTIFICATE OF DEATH

02248

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> c. LENGTH OF STAY in b <b>22 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5705 AGER ROAD</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEO.</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> d. STREET ADDRESS <b>5705 AGER ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELOISE WOOTEN</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>8</b> Year <b>1961</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>5/5/80</b>		9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>			
11. BIRTHPLACE (County & State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>RICHARD WOOTEN</b>			
14. MOTHER'S MAIDEN NAME <b>MARY CAROLINE DUFFY</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>			
17. INFORMANT <b>Mr. Oscar W. May, 5705 Ager Road Hyattsville, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b> 399.0 INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>7/14</b> , 19 <b>59</b> to <b>2/8</b> , 19 <b>61</b> ; that (I) (we) last saw the deceased alive on <b>2/2</b> , 19 <b>61</b> , and that death occurred at <b>10:00</b> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>NORMAN DONAT COMEAU</b> M.D.		22b. DATE SIGNED <b>2/8/61</b>		22c. PHYSICIAN'S NAME (Type) <b>NORMAN DONAT COMEAU</b>			
22d. ADDRESS <b>3503 PENNSY ST MT RAINIER MD</b>							
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>BURIAL</b> (Specify) <b>2/10/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 14 '61</b>			
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



2272

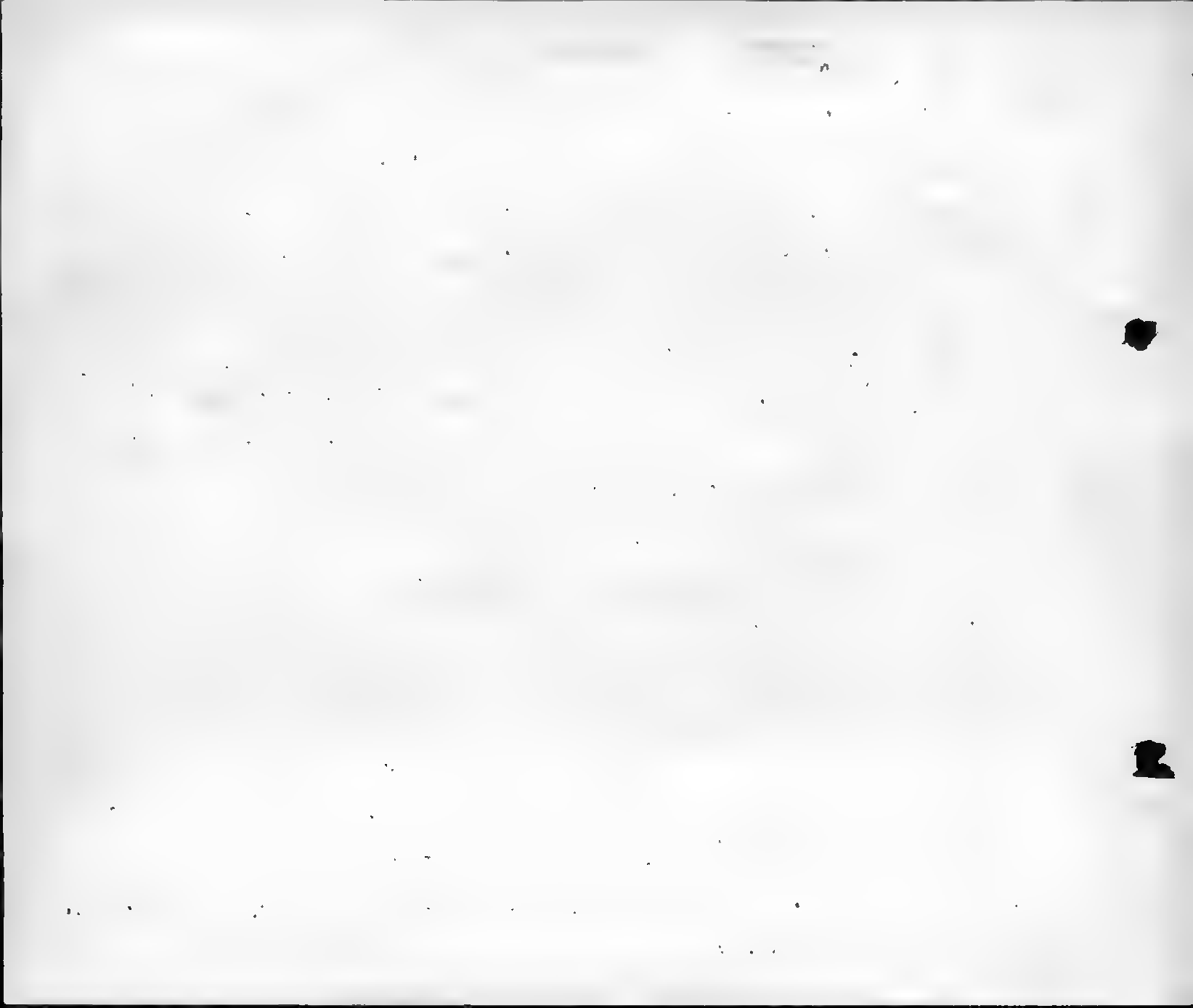
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>PRINCE GEORGES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. LENGTH OF STAY IN 1b <b>1 YR.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>401 Greenlawn Dr. Hyattsville, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>IGNATIUS</b> Last <b>MCDERMOTT</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>WH</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 14, 1887</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TICKER CLERK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PENN. R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>PHILADELPHIA PA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NEIL X Hugh McDermott</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McDermott</b> (This is correct)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> <b>WWI</b>		16. SOCIAL SECURITY NO. <b>SON</b> <b>401 GREENLAWN DR HYATTSVILLE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RESPIRATORY FAILURE</b> 332X DUE TO <b>CEREBRAL THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>GENERALIZED ARTERIO SCLEROSIS</b> DUE TO <b>SEVERAL YEARS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b>CORONARY ARTERY DISEASE</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT.</b> 1960, to <b>15 FEB</b> 1961, that I lost saw the deceased alive on <b>15 FEB</b> 1961, and that death occurred at <b>3:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Francis C Mayle Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>8218 WISCONSIN AVE</b> DATE SIGNED <b>2/15/61</b>	
PHYSICIAN'S NAME (Type) <b>FRANCIS C MAYLE JR</b>		<b>BETHESDA 14 MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington, Virginia</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nalley's Funeral Home</b> ADDRESS <b>14th Rainier</b> <b>MD</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 21 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed in pencil in item 18. Give Page, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

**2273 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02250

1. PLACE OF DEATH  
a. COUNTY **PRINCE GEORGE'S** **MARYLAND**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **CHEVERLY** **D.O.A**  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **PRINCE GEORGE'S GENERAL HOSPITAL**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE **MARYLAND** b. COUNTY **PRINCE GEORGE'S**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Suitland**  
d. STREET ADDRESS **3950 Suitland Road Apt #101**

3. NAME OF DECEASED (Type or print) **William Souder McKimney**  
4. DATE OF DEATH **Feb. 4, 1961**

5. SEX **MALE** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **Sept. 4, 1919**  
9. AGE (In years; if under 1 year, if under 24 hours last birthday) **41** yrs. **41** months **4** days **101** hours **1** min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Bus Driver** 10b. KIND OF BUSINESS OR INDUSTRY **Capital Transit** 11. BIRTHPLACE (State or foreign country) **Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Harry C. McKimney** 14. MOTHER'S MAIDEN NAME **Sergeny Souder**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **World W.2** 16. SOCIAL SECURITY NO. **578-14-2237** 17. INFORMANT **Elmer A. Pierce** Address **4036 Alabama Ave., S.E. Wash. D.C.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Acute Barbiturate poisoning**  
DUE TO  
Conditions, if any, which gave rise to immediate cause (b)  
(a), stating the underlying cause last. DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: **Depressed & ; Chronic Nephritis**

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) **Took twenty (20) Truina Capsules**

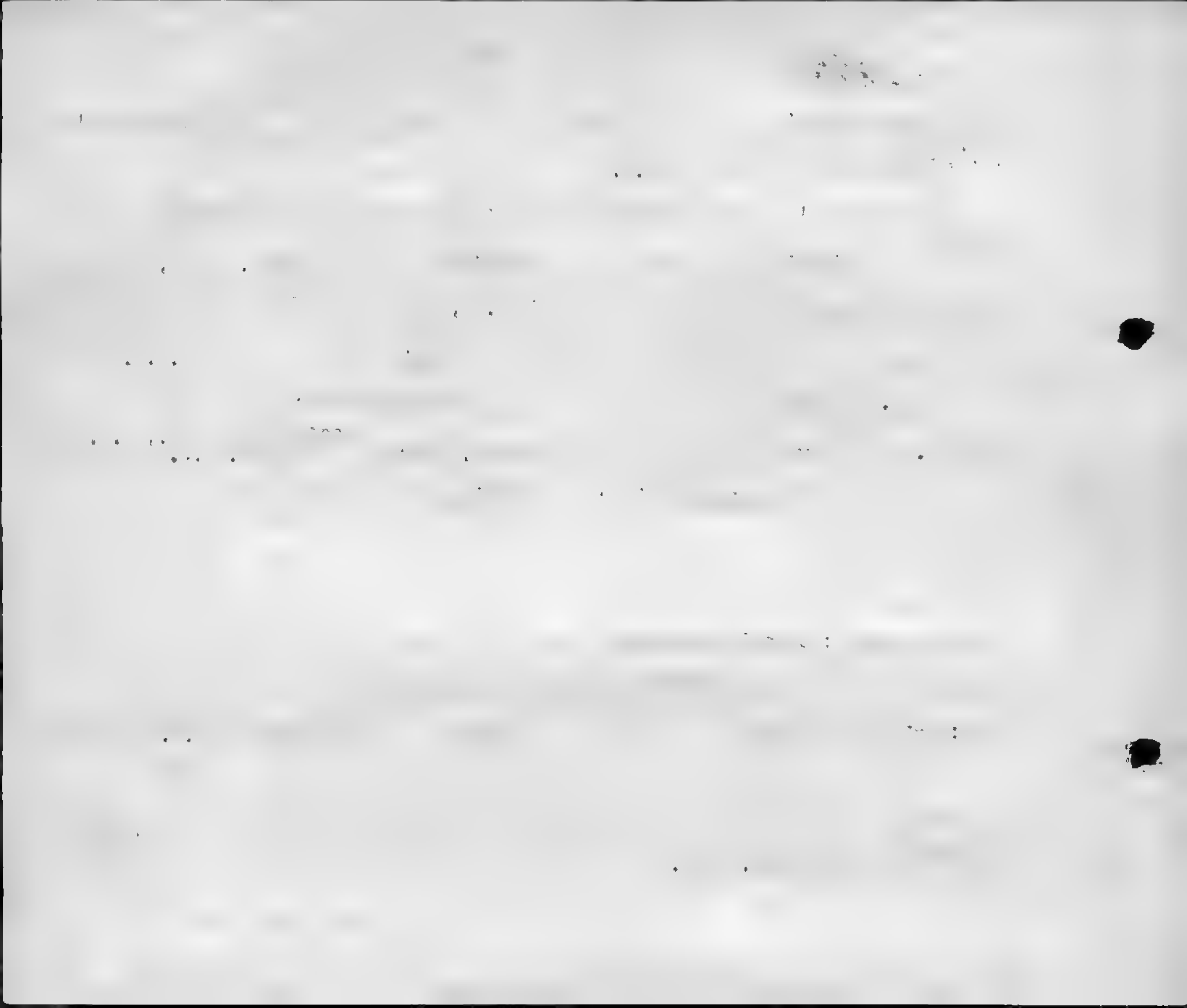
20c. TIME OF INJURY Month, Day, Year **11:30 a.m. 2/4/1961** 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **Home** 20f. (City or town) **Suitland** (County) **P.G.** (State) **Maryland**

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐

EXAMINER'S SIGNATURE **James I. Boyd** CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) **JAMES I. BOYD.** ASS STANT MEDICAL EXAMINER ☐  
DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED **2/4/61**  
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 22b. DATE THEREOF **2-8-61** 22c. NAME OF CEMETERY OR CREMATORY **Arlington Natl.** 22d. LOCATION (City, town, or country) **Arlington Va.**

23. FUNERAL DIRECTOR **Simmons Bros.** ADDRESS **1661 - Good Hope Rd SE Wash. 20 D.C.** 24a. REC'D BY REGISTRAR **FEB 6 '61** 24b. REGISTRAR'S SIGNATURE **Arthur J. H...**





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

2274

02251

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>9 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>4515 Burlington Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Loraine</b> Middle <b>McKinstry</b> Last <b>McKinstry</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1961</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>Sept 15, 1893</b>		9. AGE (In years last birthday) <b>67</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>George Fromang</b>				14. MOTHER'S MAIDEN NAME <b>Eda Laubscher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>		17. INFORMANT Address <b>Dr V. L. Fromang Vero Beach Florida.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of the</b> <b>114x</b> DUE TO <b>Carcinoma of Uterus.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 17</b> <b>1961</b> to <b>Feb 26</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>Feb 26</b> <b>1961</b> , and that death occurred at <b>7:05 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Aaron Deitz</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-27-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b>				22d. ADDRESS <b>4314 Gallatin St. Hyattsville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 28, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 2 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

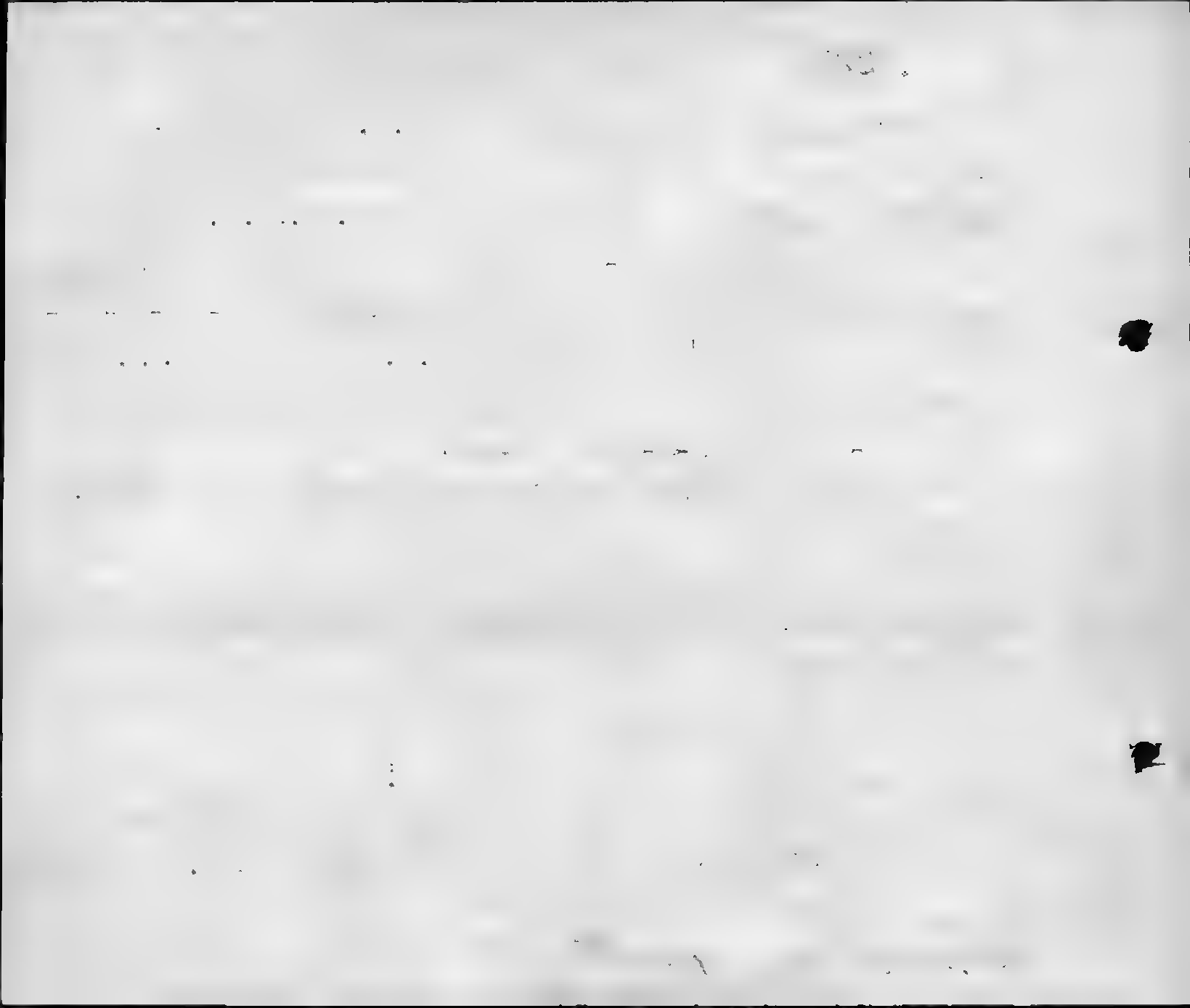


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2275 CERTIFICATE OF DEATH 02252											
1. PLACE OF DEATH a. COUNTY Prince Georges				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY D.C. c. CITY OR TOWN If outside corporate limits, write RURAL and give nearest town Washington d. STREET ADDRESS 1810 T. St., N. W.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. LENGTH OF STAY in institution 1 month and 21 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				3. NAME OF DECEASED (Type or print) John - McLeod				4. DATE OF DEATH 2 27 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/25/1899		9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY O'Donnells Sea-Grill				11. BIRTHPLACE (Country & State, or foreign country) S. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John McLeod				14. MOTHER'S MAIDEN NAME Mattie ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 578-16-1661				17. INFORMANT Decedent				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis, far advanced											
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Left nephrectomy 1939; partial gastrectomy 1955; diabetes mellitus, mild											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from... 1/6/1961 to 2/27/1961 that (I) (we) last saw the deceased alive on... 2/27/1961, and that death occurred at... 1:45 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Moe Weiss											
22b. DATE SIGNED 2/27/1961											
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.											
22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 3-4-61 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial 23d. LOCATION (City, town or county, (State)) Suitland 727d.											
24. FUNERAL DIRECTOR'S SIGNATURE John A. Latney											
25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
DATE MAR 3 '61 Arthur S. Frank											

1822-11th St NW  
Wash DC.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

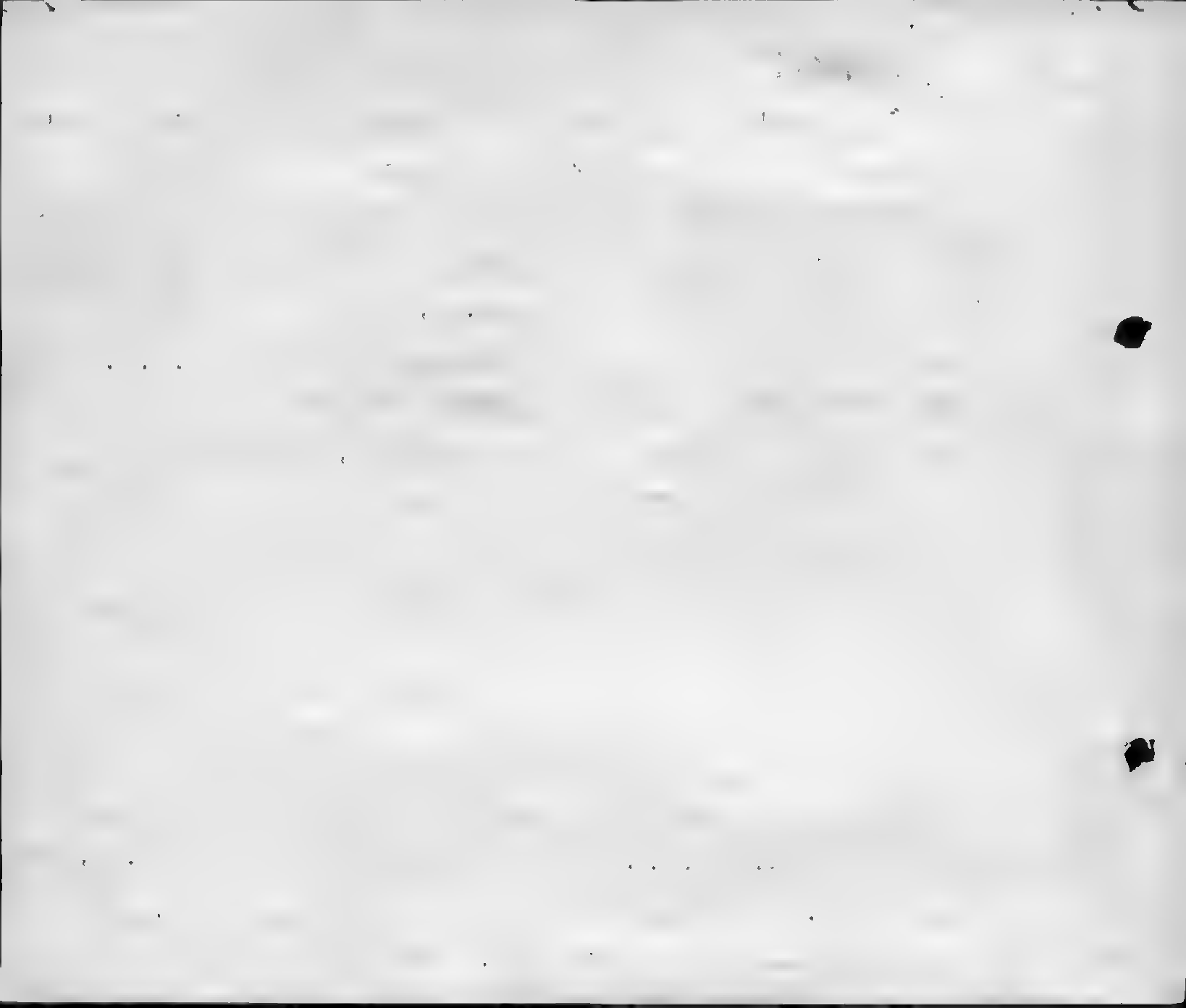
VS. A15ME  
SM 1/59  
Hass

MD  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2276 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02253

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE</b> c. LENGTH OF STAY IN 1b <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LELAND MEMORIAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>1016 Marton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daniel Lawrence McNabb</b>		4. DATE OF DEATH <b>February 12, 1961</b>		5. SEX <b>MALE</b>	
6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 26, 1960</b>	
9. AGE (In years, last birthday) <b>4</b> yrs. <b>17</b> months <b>17</b> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Joseph McNabb</b>		14. MOTHER'S MAIDEN NAME <b>JEANNE Jeanne Garre</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>John Joseph McNabb, Same as # 2</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 14, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Baltimore Md.</b>		23. FUNERAL DIRECTOR <b>C. Vernon Johnson</b> ADDRESS <b>4611 Park Heights Ave.</b>	
24a. REC'D BY REGISTRAR <b>FEB 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Feb. 12, 1961</b>	



2277

## CERTIFICATE OF DEATH

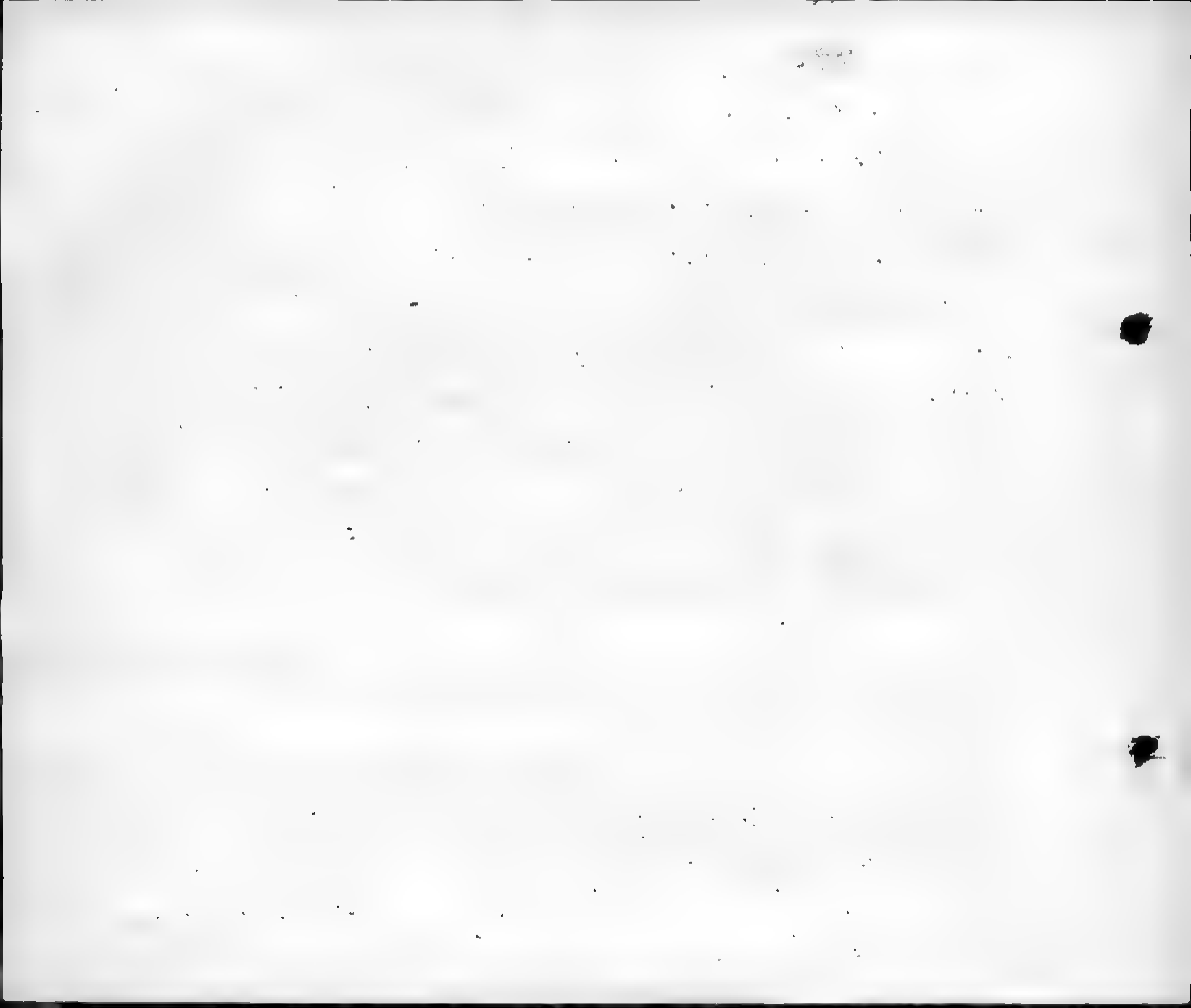
Reg. Dist. No.

02254

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. LENGTH OF STAY IN 1b <u>37 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3608-Bunker Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Scott Armed Melius</u>		4. DATE OF DEATH <u>Feb. 1st</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 22 / 85</u> 19 <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Allentown, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Martin Luther Melius</u>		14. MOTHER'S MAIDEN NAME <u>Mary Knight</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>_____</u> (If yes, give war or dates of service) <u>_____</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC Ht Disease</u> 420.09 DUE TO <u>Severe bridged arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>_____</u> DUE TO <u>_____</u> (c) <u>_____</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Isaaplegia due to CVA</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-15 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>_____</u> 19 <u>_____</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State) <u>_____</u>	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>_____</u> to <u>Jan</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>61</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon R. Gallin MD</u>		ADDRESS (Street, city or town, state) <u>W. Hg ATTsville, Md.</u> DATE SIGNED <u>_____</u>	
PHYSICIAN'S NAME (Type) <u>LEON R. GALLIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/4/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>_____</u> 24b. REGISTRAR'S SIGNATURE <u>_____</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner's papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

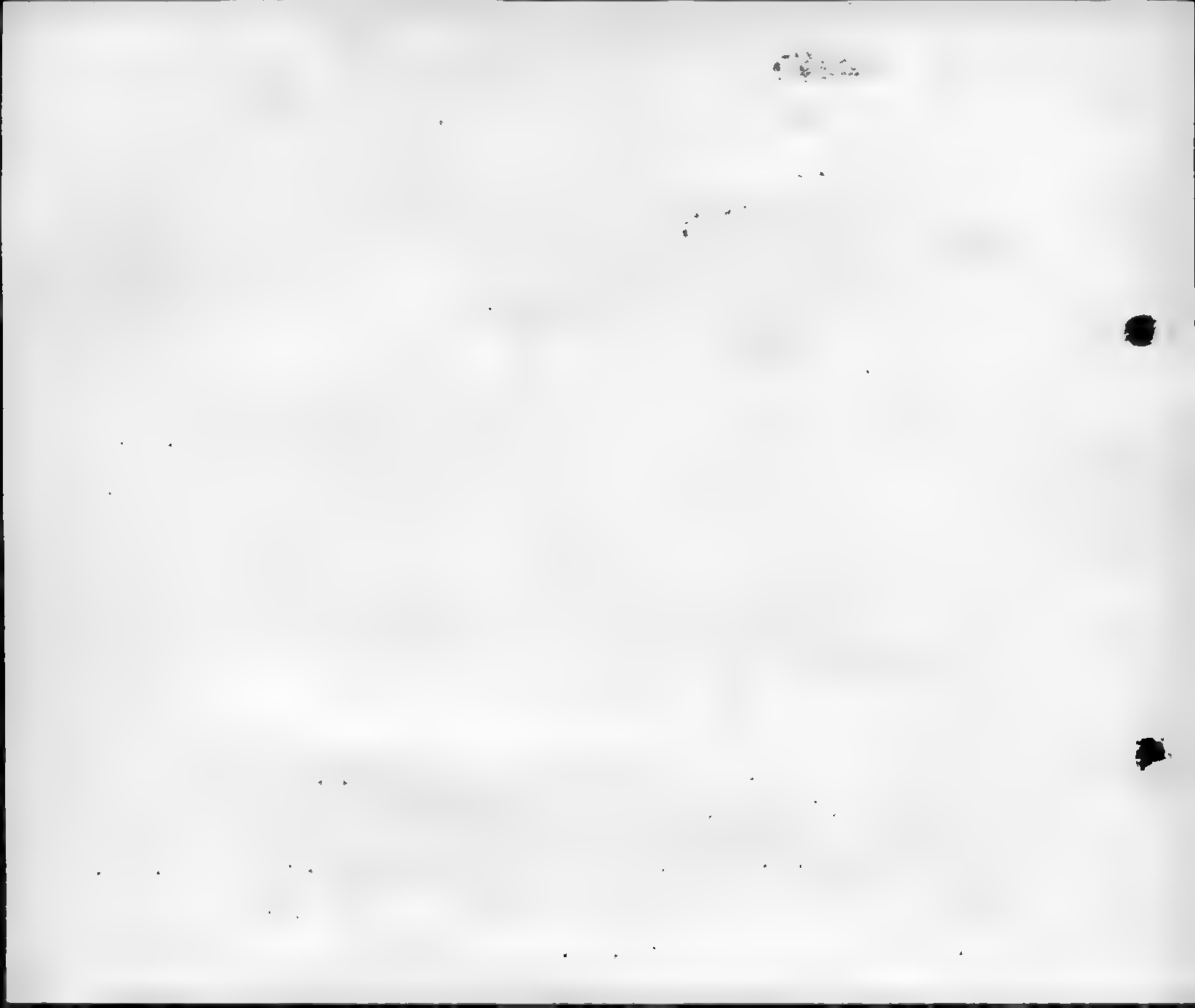
2278

CERTIFICATE OF DEATH

02255

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>2 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>4216 A Knox Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Tracy</b> Middle <b>Alison</b> Last <b>Mennard</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1961</b>
9. AGE (in years last birthday) <b>2</b>		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Michael Mennard</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Lee Beecher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO <b>----</b>	
17. INFORMANT <b>Hospital record</b>		Address <b>Cheverly Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Mass</b> DUE TO <b>Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>17ix</b> DUE TO <b>11 hours</b> (c) <b>Interval between onset and death</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> that (I) (we) last saw the deceased alive on <b>Feb. 18</b> <b>1961</b> and that death occurred at <b>2:40 PM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Mary K. L. Sartwell</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Mary K.L. Sartwell</b>		22d. ADDRESS <b>6811 Riggs Road, Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 24, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>Hyattsville, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Carling E. Kneass</b>		DATE <b>FEB 23 '61</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2279

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

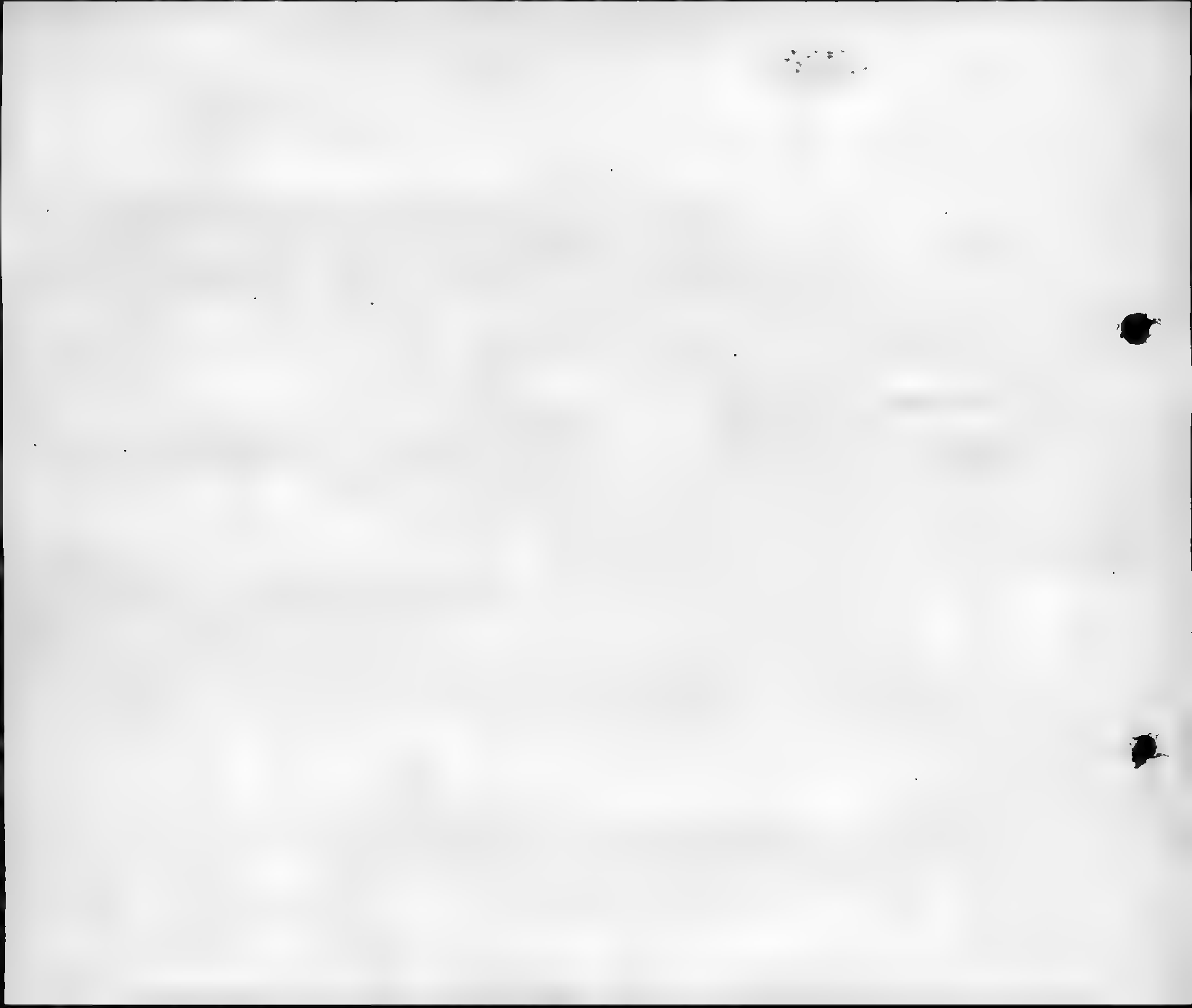
CERTIFICATE OF DEATH

02256

1 PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lannd</i>		c. LENGTH OF STAY IN 1b <i>6 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1011 Bond Mill Road</i>		d. STREET ADDRESS <i>1011 Bond Mill Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Leo</i> Middle <i>John</i> Last <i>Miemietz</i>		4. DATE OF DEATH Month <i>February</i> Day <i>14</i> Year <i>1961</i>	
5 SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 29 1916</i>
9. AGE (In years last birthday) <i>44</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>General construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Country of Latvia</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Miemietz</i>		14 MOTHER'S MAIDEN NAME <i>Agnes Kamp</i>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give war or dates of service) <i>WW 2</i>		16. INFORMANT Address <i>Robert Marion Miemietz, Lannd Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO (b) <i>Cirrhosis of Liver</i> DUE TO (c) <i>Chronic Alcoholism</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>1 year</i> <i>10 yrs</i>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>7/25</i> 19 <i>58</i> to <i>2/13</i> 19 <i>61</i> , that (I) ( <del>we</del> ) lost <del>saw</del> the deceased alive on <i>2/13</i> 19 <i>61</i> , and that death occurred at <i>11P</i> M, from the causes and on the date stated above.			
22a SIGNATURE <i>J. M. Warren</i>		22b. DATE SIGNED	
22c PHYSICIAN'S NAME (Type) <i>J. M. WARREN</i>		22d. ADDRESS	
23a BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		23b DATE THEREOF <i>2/17/61</i>	
23c NAME OF CEMETERY OR CREMATORY <i>East Lincoln</i>		23d. LOCATION (City, town, or county) (State) <i>Calverton Naval Air Station Md</i>	
24 FUNERAL DIRECTOR'S SIGNATURE <i>DeWitt Canadon</i>		25a REC'D BY REGISTRAR <i>FEB 20 61</i>	
ADDRESS <i>Lannd, Md</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

(M)

(I)

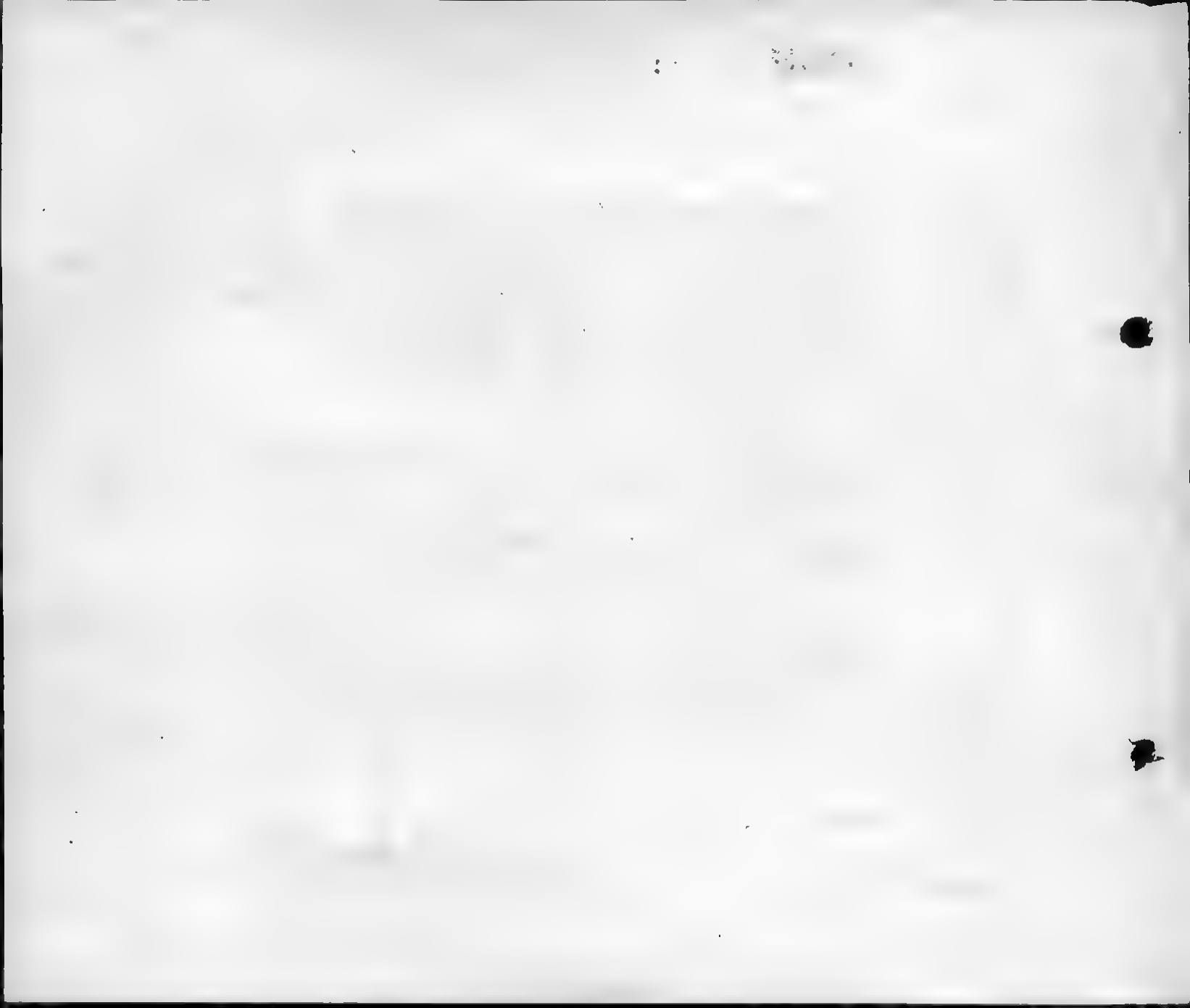


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

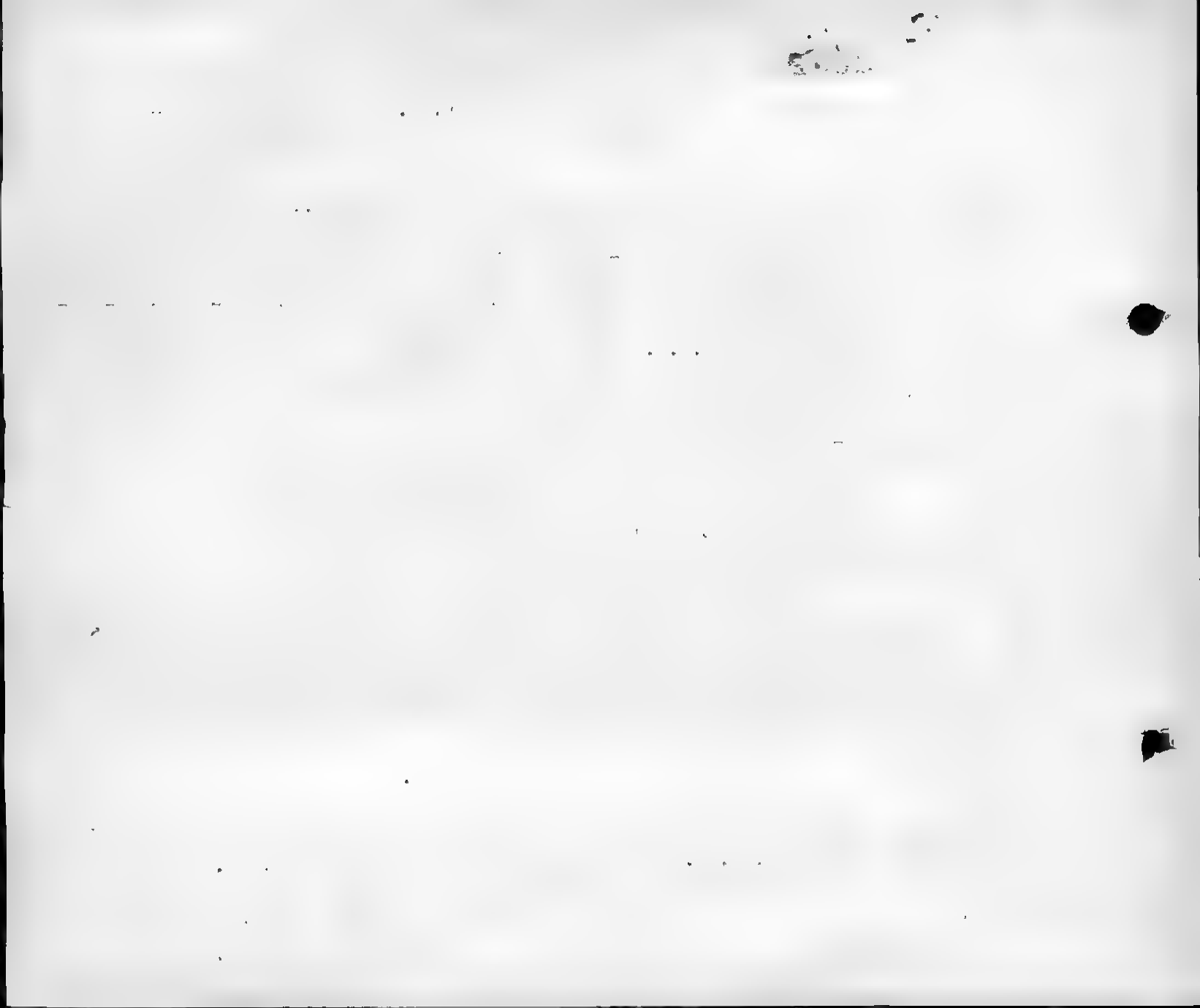
1  
2280  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02257

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Pr. George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) No. Brentwood 42	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Geo. Co Hospital		e. STREET ADDRESS 4514 Banner St.	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Ellen Moore		4. DATE OF DEATH Month Day Year Feb 1 1961	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 15 1885
9. AGE (In years last birthday) 75 76		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Fam.	
11. BIRTHPLACE (State or foreign country) Bowie Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Margaret Blackston	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Maude L. Gilbert		Address 4514 Banner St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO myocardial infarction Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Virus infection (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959, to 2-1 1961, that (I) (we) last saw the deceased alive on 1-31 1961, and that death occurred at 9 M from the causes and on the date stated above			
22a. SIGNATURE Leonard Hays		22b. DATE SIGNED 2-4-61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Hyattsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2-4-61	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn		23d. LOCATION (City, town, or county) (State) Bessing Rd SE. DC	
24. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington		25a. REC'D BY REGISTRAR DATE FEB 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Fernald			



1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2281  
CERTIFICATE OF DEATH  
02258

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 2 months & 8 days				d. STREET ADDRESS 1000 12th St., SE Apt 310			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Gertrude Middle - Last Murphy				4. DATE OF DEATH Month 2 Day 17 Year 1961			
5 SEX Female		6. COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 5/1/10	
9. AGE (In years last birthday) 50 yrs		IF UNDER 1 YEAR Months - Days -		IF UNDER 24 HRS Hours - Min -			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY D.U.C. Board		11. BIRTHPLACE (State or foreign country) Virginia	
12 CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Spriggs				14. MOTHER'S MAIDEN NAME Isabell Tyler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute hepatic decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Laennec's cirrhosis of liver DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 days Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 12/9/1960 to 2/17/1961, that (I) (we) last saw the deceased alive on 2/17/1961, and that death occurred at 4:50 P. M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss, M. D.				22b. ADDRESS Glenn Dale Hospital Glenn Dale, Md.		22c. DATE SIGNED 2/17/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 2/20/61		23c. NAME OF CEMETERY OR CREMATORY Spriggs Family Cemetery	
23d. LOCATION (City, town, or county) (State) Spottsylvania Co. Va.				23e. NAME OF CEMETERY OR CREMATORY Locust Grove, Va.		23f. ADDRESS	
24. FUNERAL DIRECTOR'S SIGNATURE Johnson				24b. REC'D BY REGISTRAR FEB 23 '61		24c. REGISTRAR'S SIGNATURE Arthur S. Hanks	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2282

02259

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY <b>471</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSPITAL ANDREWS AFB WASH 25 DC</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GRACE</b> Middle <b>MILLICENT</b> Last <b>NEWMAN</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>21</b> Year <b>19 61</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 NOVEMBER 1876</b>	9. AGE (In years, lost birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.	IF UNDER 24 HRS Hours <b>84</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>NOBLE</b>				14. MOTHER'S MAIDEN NAME <b>BIANCA DUAL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE HYPOTENSIVE EPISODE</b> DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INTRAVASCULAR THROMBOSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hours</b> <b>24 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY EMPHYSEMA AND BRONCHITIS</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9 February, 19 61</b> to <b>21 February 19 61</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>21 February 19 61</b> , and that death occurred at <b>1210A</b> from the causes and on the date stated above							
22a. SIGNATURE <b>John F. X. Cline</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>21 February 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN F. X. CLINE, (MD) CAPT USAF MC</b>				22d. ADDRESS <b>USAF HOSPITAL ANDREWS AFB WASHINGTON 25 DC</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>23 FEB. 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEE CREMATORY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>RINALDI FUNERAL HOME Inc.</b>				ADDRESS <b>816 Hst. NE. WASH DC</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony S. Kline</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. 15ME  
SM 1/59

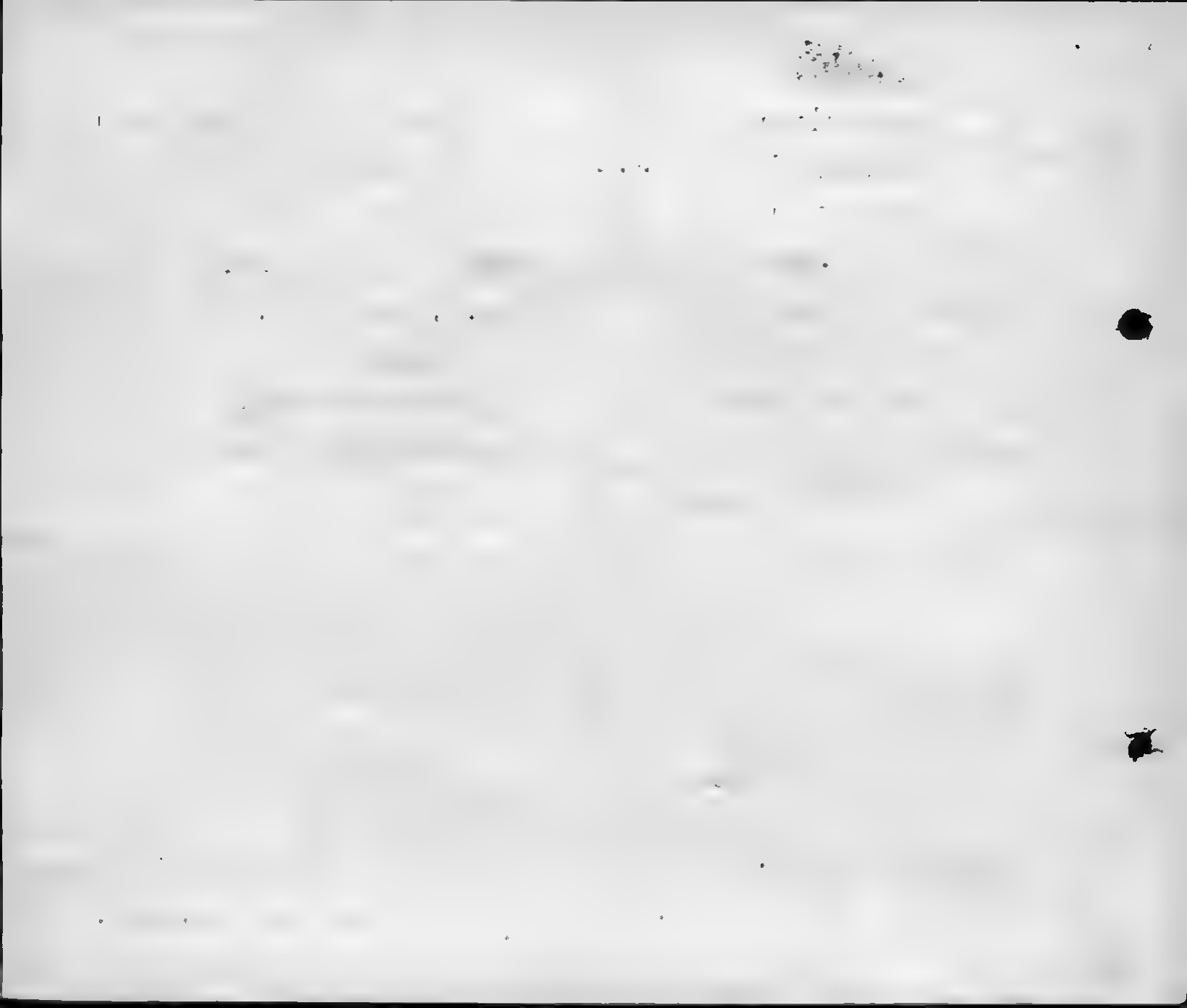
1  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

2283

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

102200

1. PLACE OF DEATH a. COUNTY <b>M</b> <b>PRINCE GEORGE'S</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>MARYLAND</b> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>UPPER MARLBORO</b>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b>				c. LENGTH OF STAY IN IL <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>				d. STREET ADDRESS <b>BOX #2367</b>			
3. NAME OF DECEASED (Type or print) <b>JEROME MARVIN NEWMAN</b>		First Middle Last		4. DATE OF DEATH <b>Feb. 4 1961</b>		Month Day Year	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>X</b>		8. DATE OF BIRTH <b>Oct. 1, 1960</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE (CHILD)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		9. AGE (In years last birthday) <b>4 Mos.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JAMES HERMAN NEWMAN</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH LENA BUTLER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>*****</b>			
17. INFORMANT <b>JAMES HERMAN NEWMAN</b>				Address <b>Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James I. Boyd</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES I. BOYD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2/6/61</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>				22d. LOCATION (City, town, or country) (State) <b>Upper Marlboro, Md.</b>			
23. FUNERAL DIRECTOR <b>Ritchie Bros. Fun'l Home-Upper Marlboro,</b>				24. REC'D BY REGISTRAR <b>DATE FEB 14 '61</b>			
24b. REGISTRAR'S SIGNATURE <b>Colleen S. Thomas</b>				DATE SIGNED <b>2/4/61</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

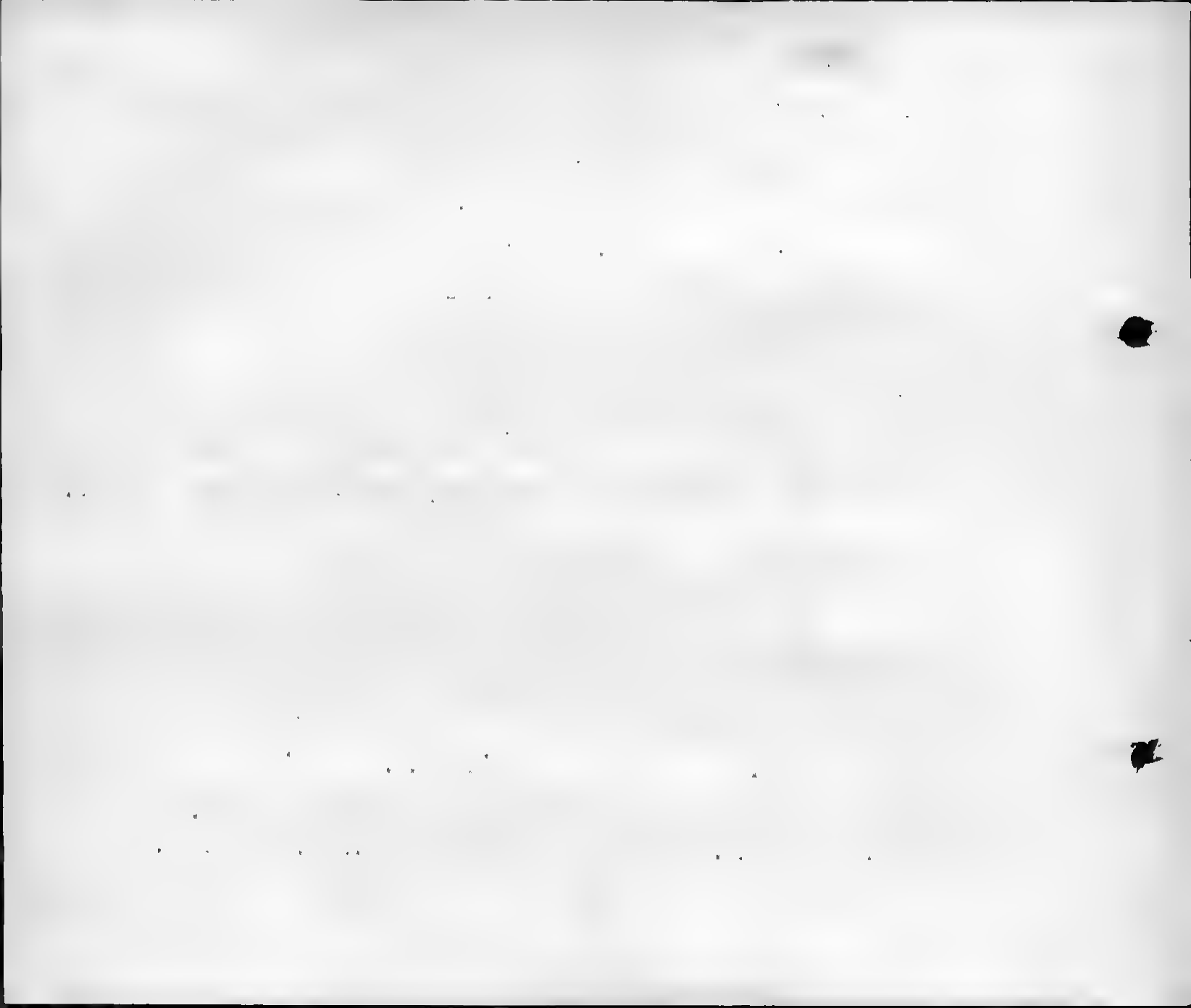
VR A15 (4)  
TSM 9/59

1  
2284  
M  
077  
I

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

0226

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>14 hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>13416 Keating Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>R.</b> Last <b>O'Brien</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-28-14</b>
9. AGE (In years last birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>3</b> Min <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>car repairman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington Terminal - Charleston S.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Aloysius O'Brien</b>		14. MOTHER'S MAIDEN NAME <b>Mattie Mae Heatley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>Ruth M. O'Brien - Wife</b>	
17. INFORMANT <b>Ruth M. O'Brien - Wife</b>		Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bilateral Lobar Pneumonia, Severe, Upper Lobes</b> 4 90 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) <b>DUE TO</b> INTERVAL BETWEEN ONSET AND DEATH <b>17 Hrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 4, 1961</b> to <b>Feb. 4, 1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 4, 1961</b> , and that death occurred at <b>8:00 p.m.</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles C. Hageage</b>		22b. DATE SIGNED <b>Feb. 4, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>Charles C. Hageage M.D.</b>		22d. ADDRESS <b>3308 Perry St., Mt. Rainier, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/8/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Belvoir</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Malley's Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 '61</b>	
ADDRESS <b>Mt. Rainier, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



1  
FOR STATE  
HEALTH DEPT.

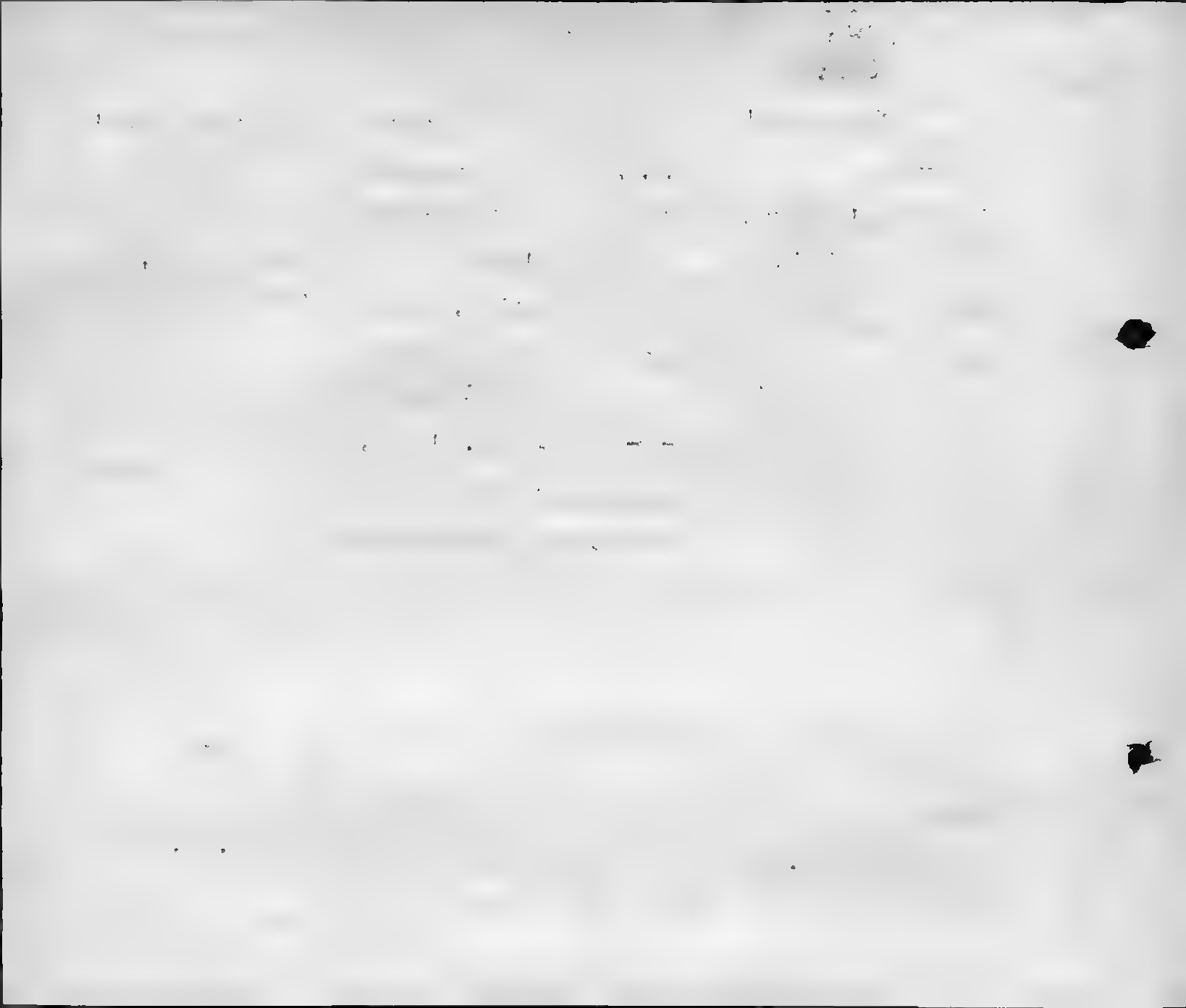
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

2283 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02262

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		
c. LENGTH OF STAY IN <b>D.O.A.</b>			d. STREET ADDRESS <b>5421 McBeth Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince George's General Hospital</b>					
3. NAME OF DECEASED (Type or print) <b>William Wilson O'Brien</b>		4. DATE OF DEATH <b>February 20, 1961</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1914</b>	9. AGE (in years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Joseph Thomas O'Brien</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Rath</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>215-16-6968</b>		17. INFORMANT <b>Emel W. O'Brien, Same as # 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b>					
(c) <b></b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b></b>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>		(County) <b></b>		(State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James I. Boyd</i>		M.D. <b></b>		DATE SIGNED <b>Feb. 20, 1961</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b></b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/23/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery Co.</b>	
22d. LOCATION (City, town, or country) <b>Leesburg, Va.</b>		22e. (State) <b></b>		22f. (County) <b></b>	
23. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>		24e. REC'D BY REGISTRAR <b>FEB 27 '61</b>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Plummer</i>		24c. DATE <b></b>		24d. REGISTRAR'S SIGNATURE <b></b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

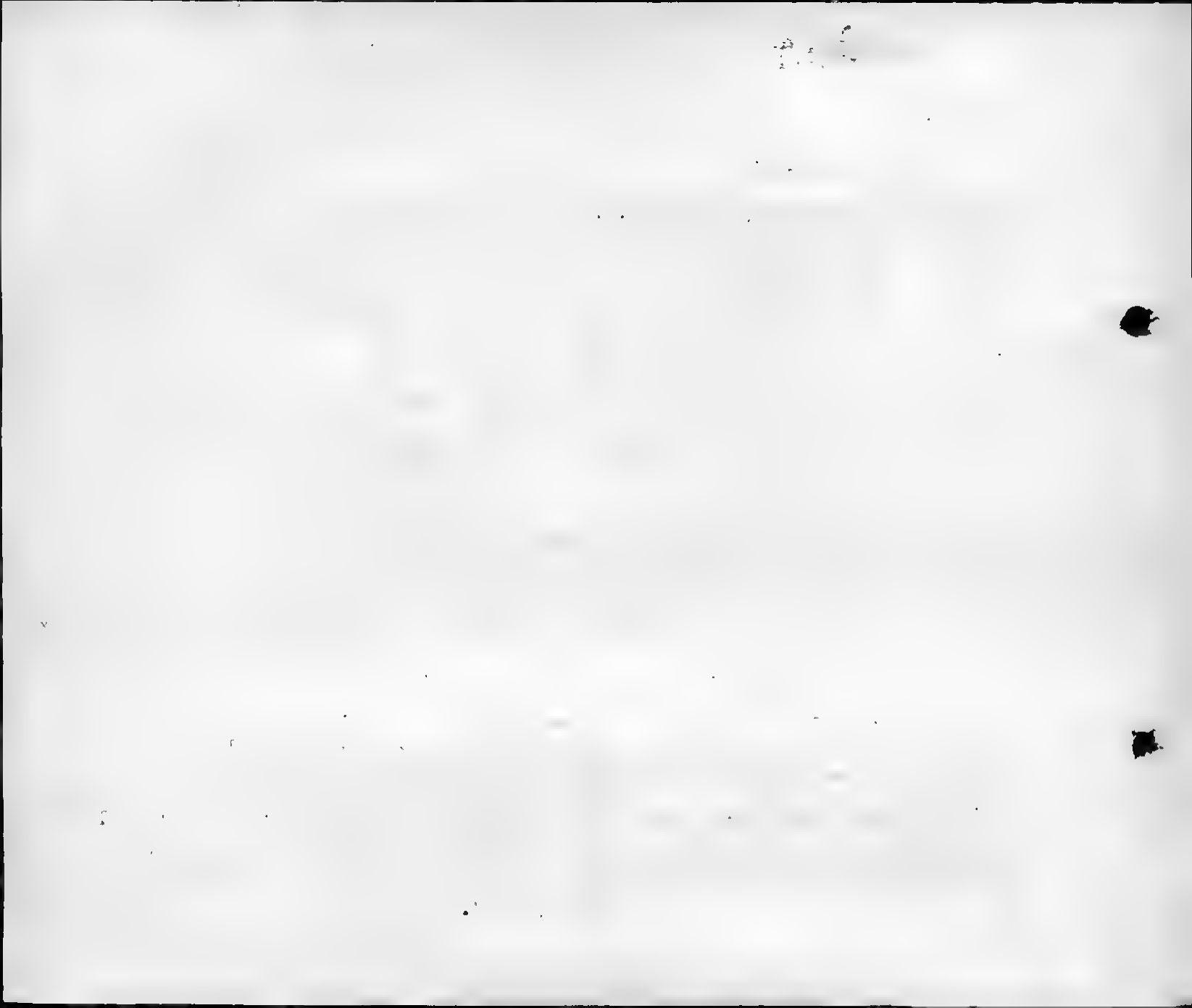
2286

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

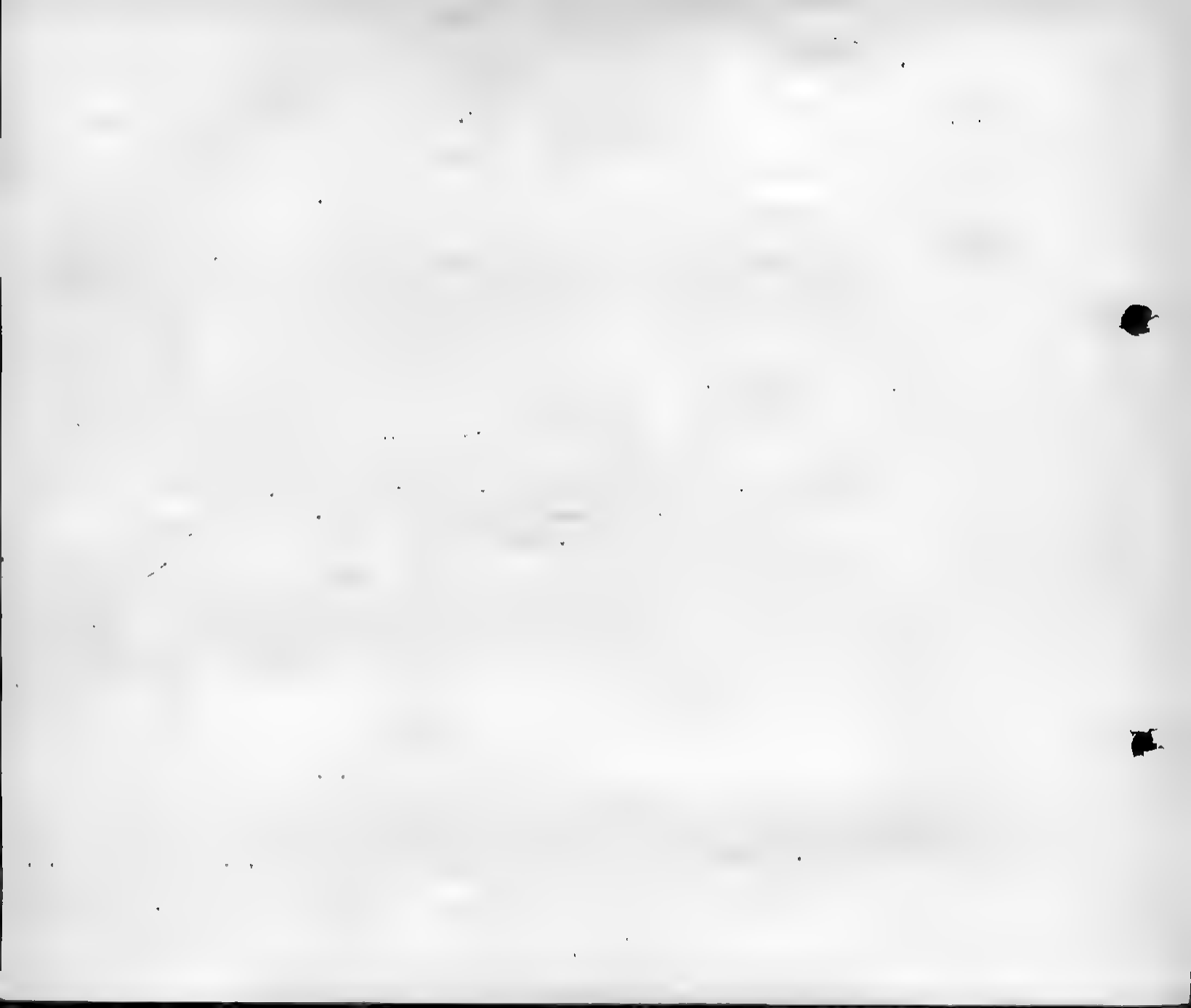
CERTIFICATE OF DEATH

02263

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b>		c. LENGTH OF STAY IN lb <b>ANDREWS AIR FORCE BASE, WASH 25 D.C.</b>		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DISTRICT HEIGHTS</b>		d. STREET ADDRESS <b>7700 DISTRICT HGTS PRKWY APT 6</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HOWARD</b>		First <b>HOWARD</b>		Middle <b>(NONE)</b>		Last <b>Frank ODELL</b>		4. DATE OF DEATH Month <b>FEBRUARY</b>		Day <b>17</b>		Year <b>19 61</b>			
5 SEX <b>MALE</b>		6 COLOR OR RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>30 NOVEMBER 1909</b>		9 AGE (In years last birthday) <b>51</b> yrs		IF UNDER 1 YEAR Months <b>51</b>		IF UNDER 24 HRS Days <b>51</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Inspector</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>				11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>				12 CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>FRANK C ODELL</b>						14. MOTHER'S MAIDEN NAME <b>WINNIE ODELL</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>231-14-3565</b>		17 INFORMANT <b>Mrs. Mary Ruth Odell (Wife)</b> <b>MRS FRANK ODELL (WIFE)</b> Same as 2									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGE</b> DUE TO <b>ACCIDENTAL GUNSHOT WOUND</b> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>IMMEDIATE</b> (c) <b>IMMEDIATE</b>												INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Accidentally shot on Andrews AFB based on investigation by FBI</b>														19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Accidentally shot on Andrews AFB based on investigation by FBI</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Accidentally shot on Andrews AFB based on investigation by FBI</b>											
20c. TIME OF INJURY Month, Day Year Hour a m <b>3:30 p.m. Feb 17 19 61</b>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Corp Engr Bldg</b>		20f. (City or town) <b>Andrews Air Force Base, MD.</b>		(County) <b>Prince Georges</b>		(State) <b>MD</b>			
21 I certify that <b>W</b> (this hospital) <b>subscribed the deceased</b> <b>DOA</b> <b>xx ON xx February 17 1961</b> , that (1) <b>W</b> last saw the deceased <b>xx</b> on <b>17 February 61</b> , and that death occurred at <b>330 PM</b> , from the causes and on the date stated above															
22a. SIGNATURE <b>THEODORE W RICHEY</b>				Major, or USAF MC		M.D. ATTENDING PHYS <input type="checkbox"/> "MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		17 February 1961		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <b>THEODORE W RICHEY</b>				Major USAF MC		22d. ADDRESS <b>USAF Hospital Andrews AFB, Wash 25, DC</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>20 Feb 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverside Memorial Park</b>				23d. LOCATION (City, town, or county) (State) <b>Hickory, Va -</b>					
24 FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>						ADDRESS <b>300-4th St. NW Wash DC</b>		25a. REC'D BY REGISTRAR <b>FEB 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>C. L. S. Kuma</b>					







# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2288 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVERLY</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tel, give street address) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EAST PINES</b> d. STREET ADDRESS <b>5723 - 64th PLACE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KENNETH WILLIAM ORNOLD</b>		4. DATE OF DEATH <b>February 4, 1961</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>July 1, 1915</b>	
9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) <b>45</b> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab Driver</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Vernon Omold</b>		14. MOTHER'S MAIDEN NAME <b>Emma Colgan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>W.W. Yes WW II</b>		16. SOCIAL SECURITY NO. <b>199-03-9652</b>	
17. INFORMANT <b>Mrs Edna Omold</b>		Address <b>5723, 64th Pl., East Pines, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate (b) <b>Myocarditis, Arteriosclerotic heart disease</b> (c), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>2/4/61</b> Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 8, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Md.</b>		24. REG. BY REGISTRAR <b>FEB 8 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

1921

1

1



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

2289

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02266

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>2810 Rhode Island Ave. N.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>M.</b> Last <b>Parke</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/10, 1894</b>		9. AGE (In years birthday) <b>66</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proprietor of Tourist Home Elk Garden, W. Va.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>Brown Anna Strothen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>578-48-5895</b>		17. INFORMANT <b>John T. Parke</b> Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.3</b> DUE TO <b>Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Primary carcinoma of sigmoid colon</b> DUE TO <b>18 months</b> (c) <b>17 months</b>				INTERVAL BETWEEN ONSET AND DEATH <b>17 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of Port I or Port II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 25</b> <b>1961</b> , to <b>Feb 8</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 8</b> <b>1961</b> , and that death occurred at <b>3 P</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>George H. McLain</b>				22b. ADDRESS <b>1746 K Street, N.W.</b>			
22c. PHYSICIAN'S NAME (Type) <b>George Henry McLain</b>				22d. DATE <b>Feb 8, 1961</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/11/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Kalley's Funeral Home, Inc.</b>				25a. RECEIVED BY REGISTRAR DATE <b>FEB 14 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	





## CERTIFICATE OF DEATH

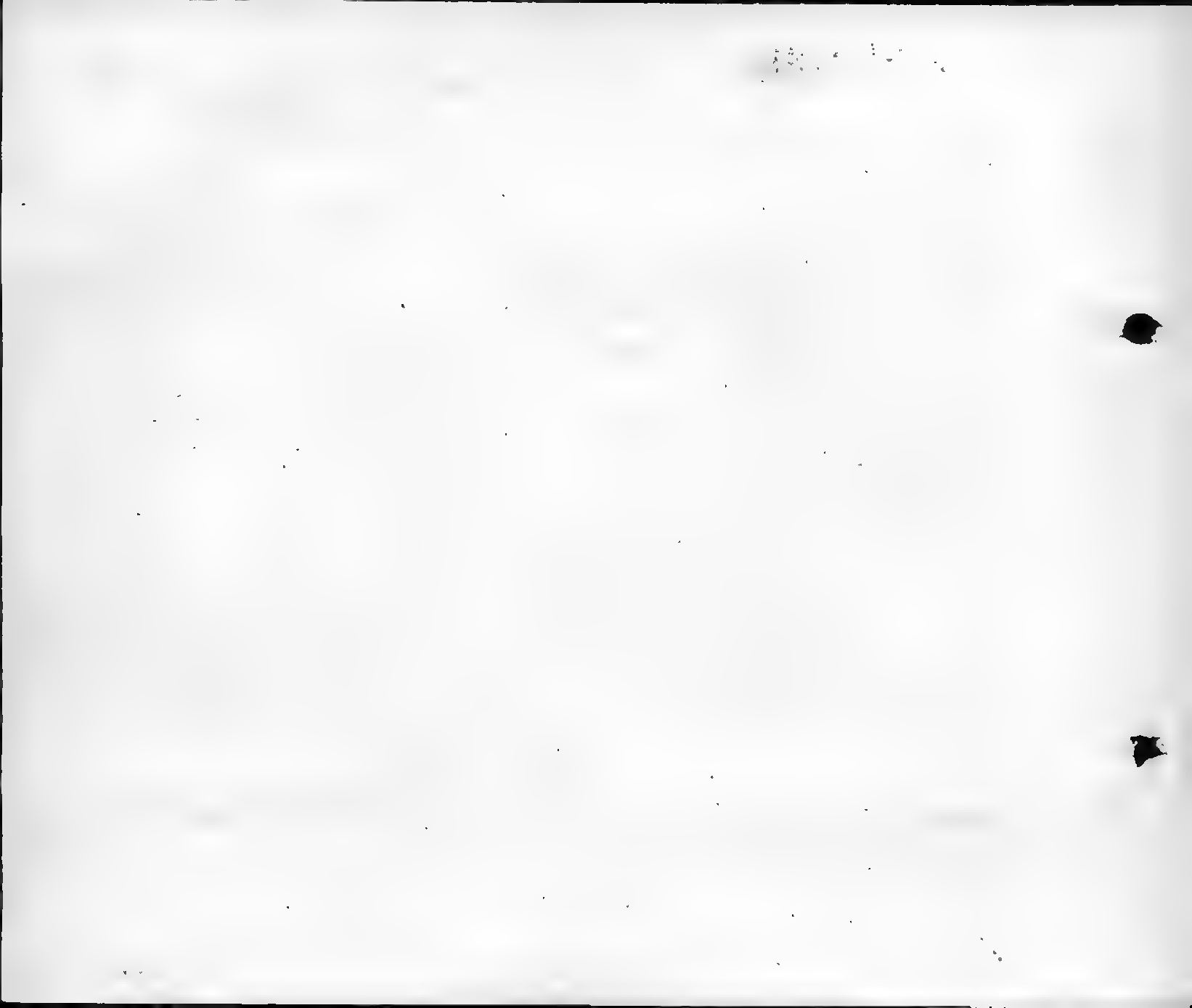
Reg. Dist. 2267

2290

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. G.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
c. LENGTH OF STAY IN TB <u>10 yrs</u>		d. STREET ADDRESS <u>RT. 2 Box 123 E</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT. 2 Box 123 E</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Irene</u> Last <u>Pratt</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep 13 1887</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min <u>73</u>	IF UNDER 24 HRS Months <u>73</u> Days <u>73</u> Hours <u>73</u> Min <u>73</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Waynesboro, Penn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Wilson A. Carroll</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth B. Sleasman</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>William T. Bowen</u> Address <u>Laurel, Va</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>593X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephritis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour <u>0</u> m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-19</u> , 19 <u>61</u> , to <u>2-5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>2-3</u> , 19 <u>61</u> , and that death occurred at <u>12:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles House</u>		ADDRESS (Street, city or town, state) <u>2-5-61 DATE SIGNED</u>	
PHYSICIAN'S NAME (Type) <u>Charles House</u>		M.D. <u>4404 Queensbury Rd. Riverdale Md.</u>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/8/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Oleth Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Randolph</u>		24a. REC'D BY REGISTRAR <u>Laurel Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		DATE <u>FEB 14 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined and within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

2291

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02263

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairmont Heights</b> d. STREET ADDRESS <b>708 60th Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Price</b> Last <b>Price</b>		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 29 1902</b>
9. AGE (In years for birthday) <b>58</b> yrs		10. IF UNDER 1 YEAR: Months <b>5</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Norristown, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Hugh T. Williams</b>		14. MOTHER'S MAIDEN NAME <b>Nettie Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hugh C. Barnes</b>		Address <b>4822 10th St., N.E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> 560.3 DUE TO <b>Post operative Abdominal Hernia Repair</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>6 Days</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 Min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 17</b> 19 <b>61</b> to <b>Feb 26</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb 26</b> 19 <b>61</b> , and that death occurred at <b>6:15 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas G. Edison M.D.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Thomas G. Edison, M.D.</b>		22d. ADDRESS <b>1015 Spring St. Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-2-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John S. Bewick</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	
26. REC'D BY REGISTRAR <b>MAR 1 '61</b>		27. REGISTRAR'S SIGNATURE	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 7159

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

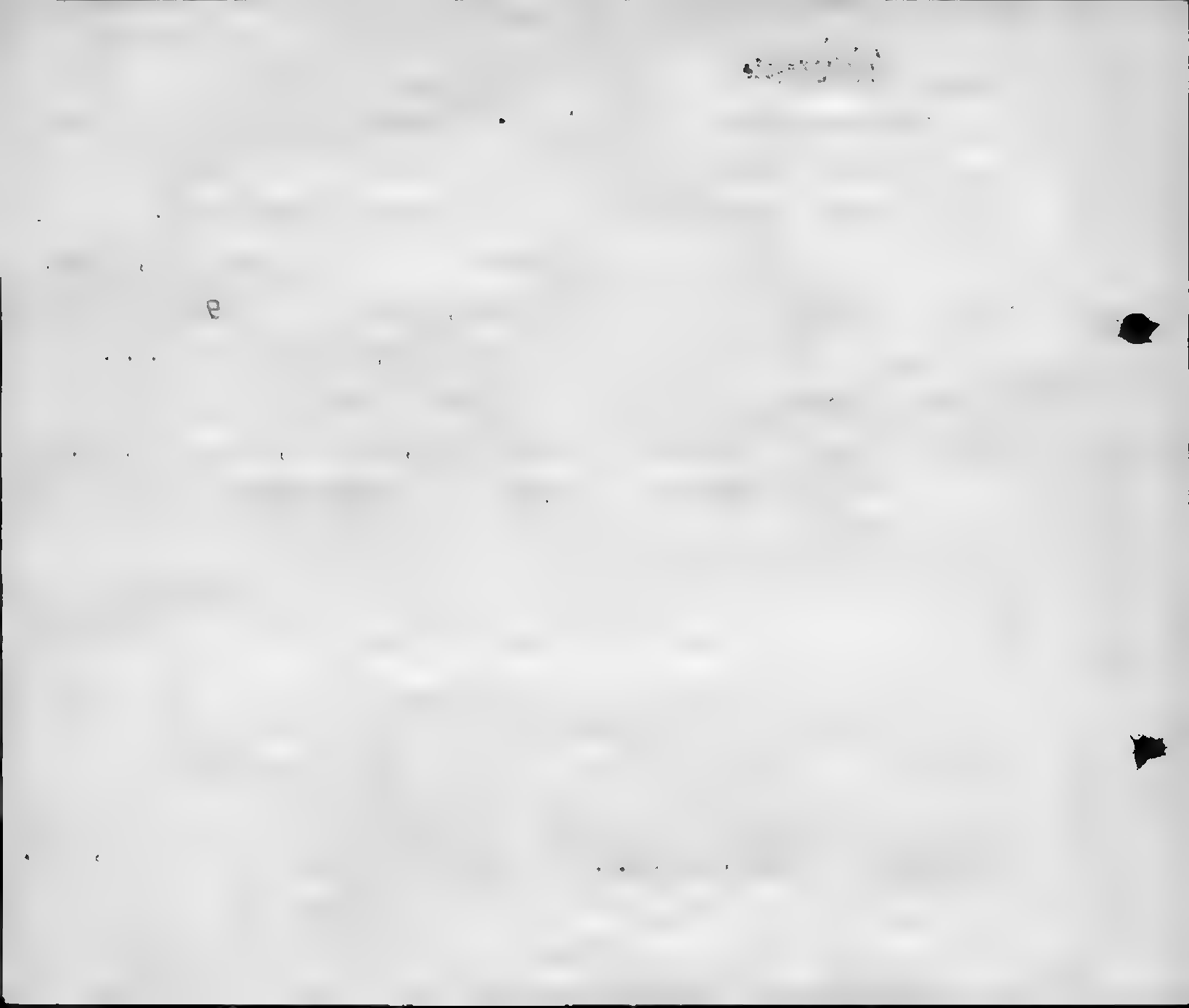
2292

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02269

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>				e. STREET ADDRESS <b>Box #64 Huntsville Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>GREGORY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 61</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 23, 1960</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>		9. AGE (In years last birthday) <b>8</b>		11. BIRTHPLACE (State or foreign country) <b>Cheverly, Maryland</b>	
13. FATHER'S NAME <b>Landon Parker</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				14. MOTHER'S MAIDEN NAME <b>Edith Queen</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Edith Queen, Box #64, Huntsville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>11. Influenza</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
SIGNATURE <b>JAMES I. BOYD, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. DATE THEREOF <b>2-15-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Md.</b>		DATE SIGNED <b>February 10, 1961.</b>	
23. FUNERAL DIRECTOR <b>H.S. Washington &amp; Sons - 4925 - Belmar Ave., NE</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2293

## CERTIFICATE OF DEATH

Reg. Dist. No. 02270

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1518 Chestnut Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Richard Lee Reum</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2,</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1879</b>
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>81</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Reum</b>		14. MOTHER'S MAIDEN NAME <b>Anna ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>-----</b>	
17. INFORMANT <b>Mrs. Martha Reum Same as # 2</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>generalized arteriosclerosis</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis Heart Disease &amp; Scurvy Arthritis - extreme</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <b>0</b> m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from <b>1953</b> to <b>2/2</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1/31</b> , 19 <b>61</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. James Kurtz</b>		DATE SIGNED <b>2/2/61</b>	
PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>		M.D. <b>R F D Bowie Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/4/61</b>	22c. NAME OF CEMETERY OR <del>CHURCH</del> <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>Francis Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 6 '61</b>		24b. REGISTRAR'S SIGNATURE <b>C. S. + S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60  
61  
62  
63  
64  
65  
66  
67  
68  
69  
70  
71  
72  
73  
74  
75  
76  
77  
78  
79  
80  
81  
82  
83  
84  
85  
86  
87  
88  
89  
90  
91  
92  
93  
94  
95  
96  
97  
98  
99  
100  
101  
102  
103  
104  
105  
106  
107  
108  
109  
110  
111  
112  
113  
114  
115  
116  
117  
118  
119  
120  
121  
122  
123  
124  
125  
126  
127  
128  
129  
130  
131  
132  
133  
134  
135  
136  
137  
138  
139  
140  
141  
142  
143  
144  
145  
146  
147  
148  
149  
150  
151  
152  
153  
154  
155  
156  
157  
158  
159  
160  
161  
162  
163  
164  
165  
166  
167  
168  
169  
170  
171  
172  
173  
174  
175  
176  
177  
178  
179  
180  
181  
182  
183  
184  
185  
186  
187  
188  
189  
190  
191  
192  
193  
194  
195  
196  
197  
198  
199  
200  
201  
202  
203  
204  
205  
206  
207  
208  
209  
210  
211  
212  
213  
214  
215  
216  
217  
218  
219  
220  
221  
222  
223  
224  
225  
226  
227  
228  
229  
230  
231  
232  
233  
234  
235  
236  
237  
238  
239  
240  
241  
242  
243  
244  
245  
246  
247  
248  
249  
250  
251  
252  
253  
254  
255  
256  
257  
258  
259  
260  
261  
262  
263  
264  
265  
266  
267  
268  
269  
270  
271  
272  
273  
274  
275  
276  
277  
278  
279  
280  
281  
282  
283  
284  
285  
286  
287  
288  
289  
290  
291  
292  
293  
294  
295  
296  
297  
298  
299  
300  
301  
302  
303  
304  
305  
306  
307  
308  
309  
310  
311  
312  
313  
314  
315  
316  
317  
318  
319  
320  
321  
322  
323  
324  
325  
326  
327  
328  
329  
330  
331  
332  
333  
334  
335  
336  
337  
338  
339  
340  
341  
342  
343  
344  
345  
346  
347  
348  
349  
350  
351  
352  
353  
354  
355  
356  
357  
358  
359  
360  
361  
362  
363  
364  
365  
366  
367  
368  
369  
370  
371  
372  
373  
374  
375  
376  
377  
378  
379  
380  
381  
382  
383  
384  
385  
386  
387  
388  
389  
390  
391  
392  
393  
394  
395  
396  
397  
398  
399  
400  
401  
402  
403  
404  
405  
406  
407  
408  
409  
410  
411  
412  
413  
414  
415  
416  
417  
418  
419  
420  
421  
422  
423  
424  
425  
426  
427  
428  
429  
430  
431  
432  
433  
434  
435  
436  
437  
438  
439  
440  
441  
442  
443  
444  
445  
446  
447  
448  
449  
450  
451  
452  
453  
454  
455  
456  
457  
458  
459  
460  
461  
462  
463  
464  
465  
466  
467  
468  
469  
470  
471  
472  
473  
474  
475  
476  
477  
478  
479  
480  
481  
482  
483  
484  
485  
486  
487  
488  
489  
490  
491  
492  
493  
494  
495  
496  
497  
498  
499  
500  
501  
502  
503  
504  
505  
506  
507  
508  
509  
510  
511  
512  
513  
514  
515  
516  
517  
518  
519  
520  
521  
522  
523  
524  
525  
526  
527  
528  
529  
530  
531  
532  
533  
534  
535  
536  
537  
538  
539  
540  
541  
542  
543  
544  
545  
546  
547  
548  
549  
550  
551  
552  
553  
554  
555  
556  
557  
558  
559  
560  
561  
562  
563  
564  
565  
566  
567  
568  
569  
570  
571  
572  
573  
574  
575  
576  
577  
578  
579  
580  
581  
582  
583  
584  
585  
586  
587  
588  
589  
590  
591  
592  
593  
594  
595  
596  
597  
598  
599  
600  
601  
602  
603  
604  
605  
606  
607  
608  
609  
610  
611  
612  
613  
614  
615  
616  
617  
618  
619  
620  
621  
622  
623  
624  
625  
626  
627  
628  
629  
630  
631  
632  
633  
634  
635  
636  
637  
638  
639  
640  
641  
642  
643  
644  
645  
646  
647  
648  
649  
650  
651  
652  
653  
654  
655  
656  
657  
658  
659  
660  
661  
662  
663  
664  
665  
666  
667  
668  
669  
670  
671  
672  
673  
674  
675  
676  
677  
678  
679  
680  
681  
682  
683  
684  
685  
686  
687  
688  
689  
690  
691  
692  
693  
694  
695  
696  
697  
698  
699  
700  
701  
702  
703  
704  
705  
706  
707  
708  
709  
710  
711  
712  
713  
714  
715  
716  
717  
718  
719  
720  
721  
722  
723  
724  
725  
726  
727  
728  
729  
730  
731  
732  
733  
734  
735  
736  
737  
738  
739  
740  
741  
742  
743  
744  
745  
746  
747  
748  
749  
750  
751  
752  
753  
754  
755  
756  
757  
758  
759  
760  
761  
762  
763  
764  
765  
766  
767  
768  
769  
770  
771  
772  
773  
774  
775  
776  
777  
778  
779  
780  
781  
782  
783  
784  
785  
786  
787  
788  
789  
790  
791  
792  
793  
794  
795  
796  
797  
798  
799  
800  
801  
802  
803  
804  
805  
806  
807  
808  
809  
810  
811  
812  
813  
814  
815  
816  
817  
818  
819  
820  
821  
822  
823  
824  
825  
826  
827  
828  
829  
830  
831  
832  
833  
834  
835  
836  
837  
838  
839  
840  
841  
842  
843  
844  
845  
846  
847  
848  
849  
850  
851  
852  
853  
854  
855  
856  
857  
858  
859  
860  
861  
862  
863  
864  
865  
866  
867  
868  
869  
870  
871  
872  
873  
874  
875  
876  
877  
878  
879  
880  
881  
882  
883  
884  
885  
886  
887  
888  
889  
890  
891  
892  
893  
894  
895  
896  
897  
898  
899  
900  
901  
902  
903  
904  
905  
906  
907  
908  
909  
910  
911  
912  
913  
914  
915  
916  
917  
918  
919  
920  
921  
922  
923  
924  
925  
926  
927  
928  
929  
930  
931  
932  
933  
934  
935  
936  
937  
938  
939  
940  
941  
942  
943  
944  
945  
946  
947  
948  
949  
950  
951  
952  
953  
954  
955  
956  
957  
958  
959  
960  
961  
962  
963  
964  
965  
966  
967  
968  
969  
970  
971  
972  
973  
974  
975  
976  
977  
978  
979  
980  
981  
982  
983  
984  
985  
986  
987  
988  
989  
990  
991  
992  
993  
994  
995  
996  
997  
998  
999  
1000

2294

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02221

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN lb <u>17 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Leland Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
f. STREET ADDRESS <u>Allens Cabin #4</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Hilda Mae Richard</u>		4. DATE OF DEATH Month Day Year <u>Feb 6 1961</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 7, 1919</u>
9. AGE (In years last birthday) <u>42</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Shardswood</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Record-</u>	
17. INFORMANT <u>Hospital Record-</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>Chronic Glomerular Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 yrs</u> <u>undetermined</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 20, 1961</u> to <u>Feb 6, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 6, 1961</u> , and that death occurred at <u>7:00</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>L W Malin</u>		22b. DATE SIGNED <u>Feb 6, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>L W Malin MD</u>		22d. ADDRESS <u>Laurel Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/9/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cpn</u>		23d. LOCATION (City, town, or county) (State) <u>Calverton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Lossaldson</u>		25. REC'D BY REGISTRAR <u>3/5 Tabott</u>	
25a. DATE <u>FEB 14 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton E. Hession</u>	















1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2295 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN <b>MD</b> <b>Dead on arrival</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince George's General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> d. STREET ADDRESS <b>2811 Crest Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Watts Richardson</b>		4. DATE OF DEATH <b>February 18, 1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1921</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Charles Watts Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Nancy K. Jarrett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes WW II</b>		17. INFORMANT <b>Mrs Virginia Richardson, same as "2"</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>James I. Boyd</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 20 '61</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTE.** **PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2296

**CERTIFICATE OF DEATH**

03485

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>35 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b>		X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>Inglewood Farms</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Helen</b> First <b>Briscoe</b> Middle <b>Roberts</b> Last				4. DATE OF DEATH <b>Feb</b> Month <b>15</b> Day <b>1961</b> Year			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 30, 1894</b>	
9. AGE (In years last b. rthday) <b>66</b> yrs		IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b> Hours <b>15</b> Min.		IF UNDER 24 HRS			
10a. US. OCCUPATION (Give kind of work done during last 12 months, even if retired) <b>Manager of own Farm</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>Rx Lindin Briscoe</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (If yes, give war or dates of service)) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Hospital Record</b> Address <b>Same as Item 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Haemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 13, 1961</b> to <b>Feb 15, 1961</b> that (I) (we) last saw the deceased alive on <b>Feb 15, 1961</b> and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Robert McCeney</b>				22b. PHYSICIAN'S NAME (Type) <b>Robert McCeney, M.D.</b>		22c. DATE SIGNED <b>2/15/61</b>	
22d. ADDRESS <b>Leland Memorial Hospital Riverdale, Md.</b>							
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/18/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Trinity Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Collington, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Home - Upper Marlboro, Md.</b>				25a. REC'D BY REGISTRAR <b>MAR 13 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

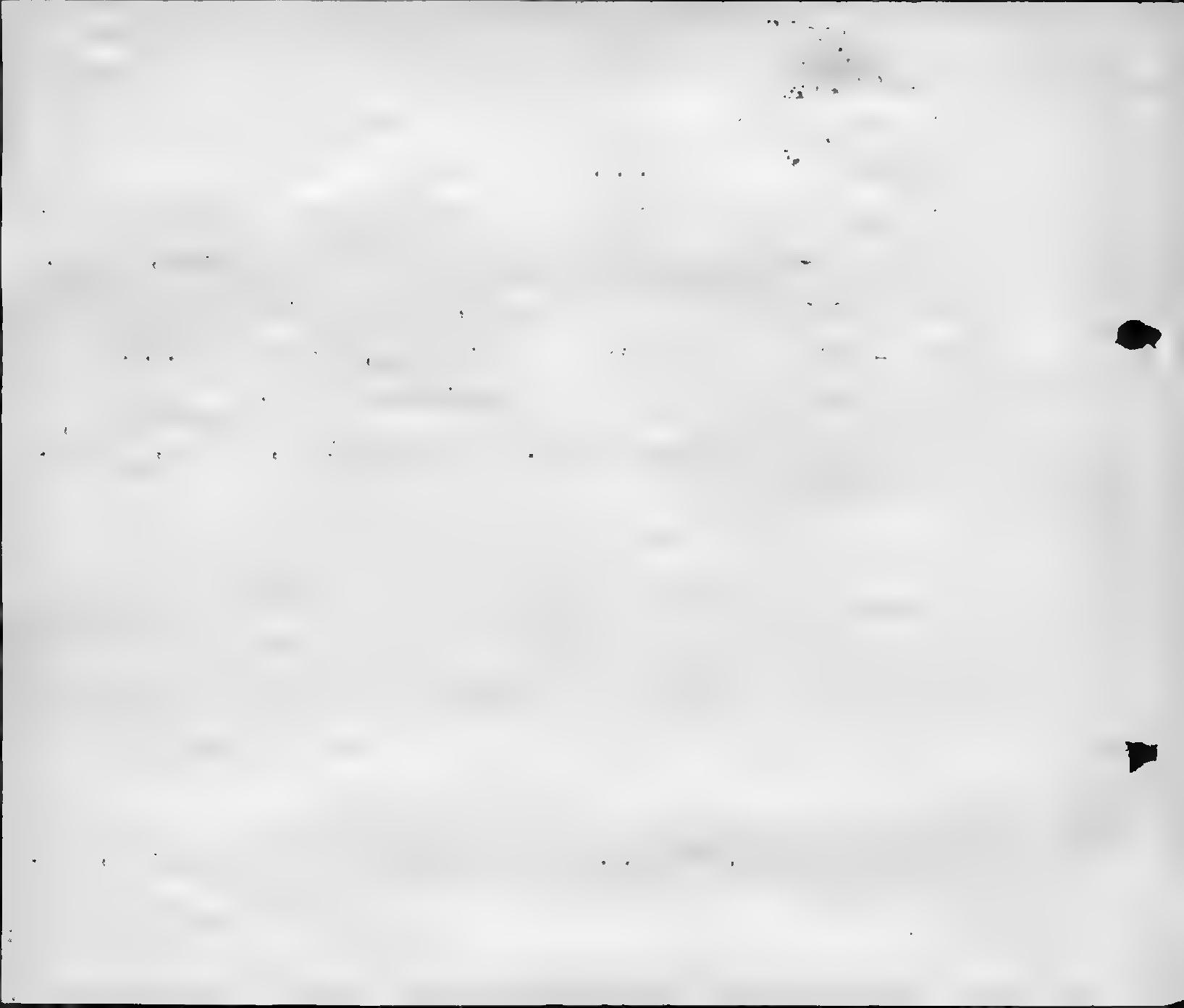
31  
FOR STATE  
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2297 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02273									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>619 8th Street</b>		g. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 61.</b>		h. AGE (In years last birthday) <b>36 5/8</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT EDWARD ROBINSON</b>		4. DATE OF BIRTH <b>June 17, 1904</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer - Retired</b>		9. BIRTHPLACE (State or foreign country) <b>Cecil County, Maryland</b>		10. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		12. DATE OF DEATH <b>February 11, 19 61.</b>	
13. FATHER'S NAME <b>George Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Robinson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mrs. Ellen Irene Robinson, Laurel, Maryland.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore, Md</b>		20g. (County) <b>Baltimore</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>February 11, 1961.</b>	
ACTUAL SIGNATURE <b>James I. Boyd</b>		EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-15-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>National</b>	
22d. FUNERAL DIRECTOR <b>Robert L. Snowden</b>		22e. ADDRESS <b>Rockville, Md.</b>		22f. LOCATION (City, town, or country) <b>Baltimore, Md</b>		22g. (State) <b>Md</b>		22h. REC'D BY REGISTRAR <b>FEB 15 '61</b>	
22i. REGISTRAR'S SIGNATURE <b>William S. Thoms</b>		22j. (City, town, or country) <b>Baltimore, Md</b>		22k. (County) <b>Baltimore</b>		22l. (State) <b>Md</b>		22m. (Country) <b>USA</b>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2298

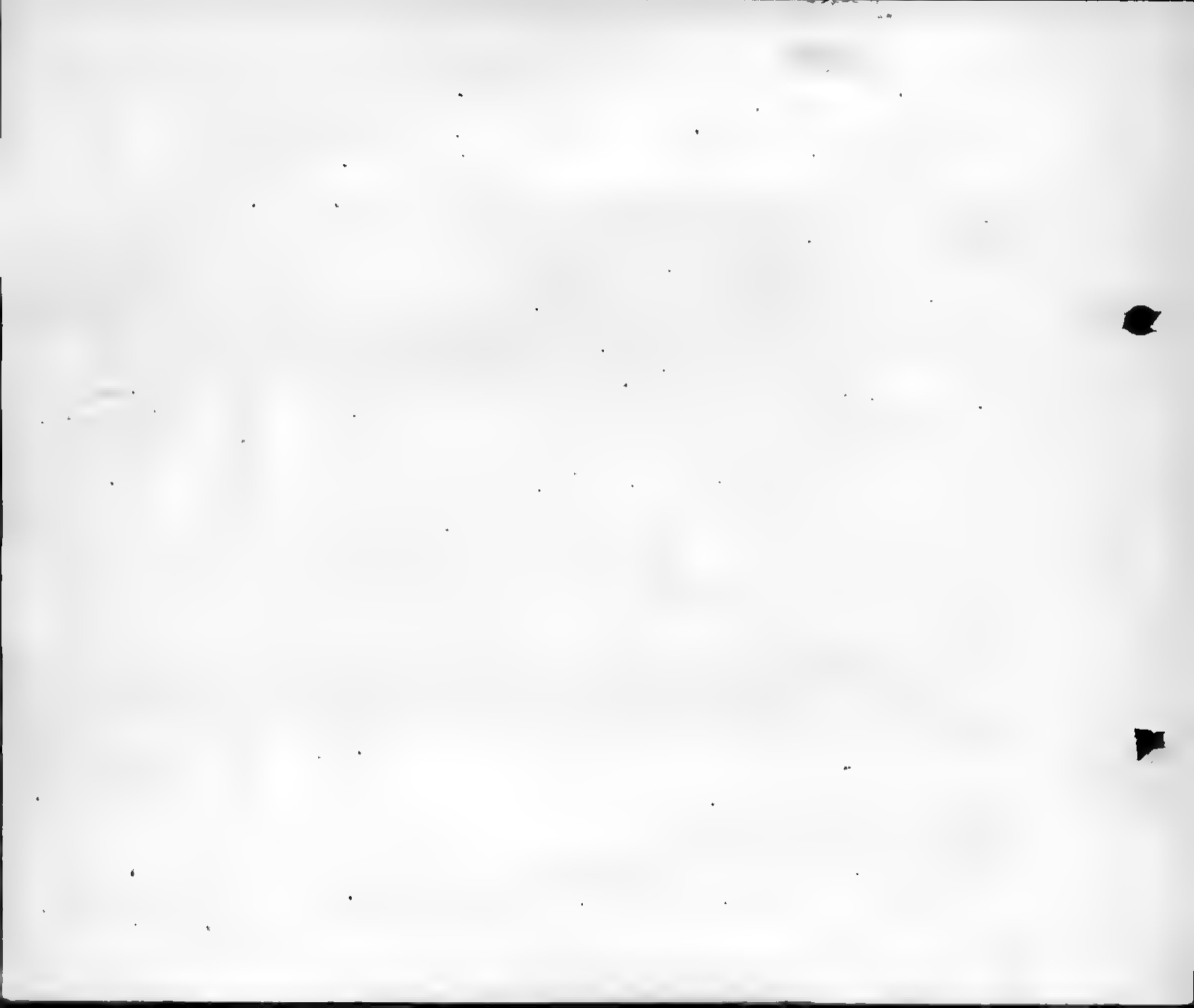
## CERTIFICATE OF DEATH

Reg. Dist. No. 02274

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u> 48	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General</u>		d. STREET ADDRESS <u>4205-29th Street</u>	
3. NAME OF DECEASED (Type or print) <u>Fred S. Roland</u>		4. DATE OF DEATH <u>Feb. 8</u> 19 <u>61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/2/1885</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>5</u> Hours <u>15</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Roland</u>		14. MOTHER'S MAIDEN NAME <u>Frances Cannon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Informant</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>15 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , 19 <u>61</u> , to <u>Feb 8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 6</u> , 19 <u>61</u> , and that death occurred at <u>Mt. Rainier</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lou L. Gallin</u>		ADDRESS (Street, city or town, state) <u>7206 Coleville Rd</u> DATE SIGNED <u>2/10/61</u>	
PHYSICIAN'S NAME (Type) <u>LEON L. GALLIN</u>		W. Hyattsville, Md	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Rainier Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Huns</u>	
ADDRESS <u>Mt. Rainier Md</u>		DATE <u>FEB 14 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. The law requires that the death certificate be extended within 24 hours after death. The law requires that the death certificate be extended within 24 hours after death.

Item 20 Film 281

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2299

CERTIFICATE OF DEATH

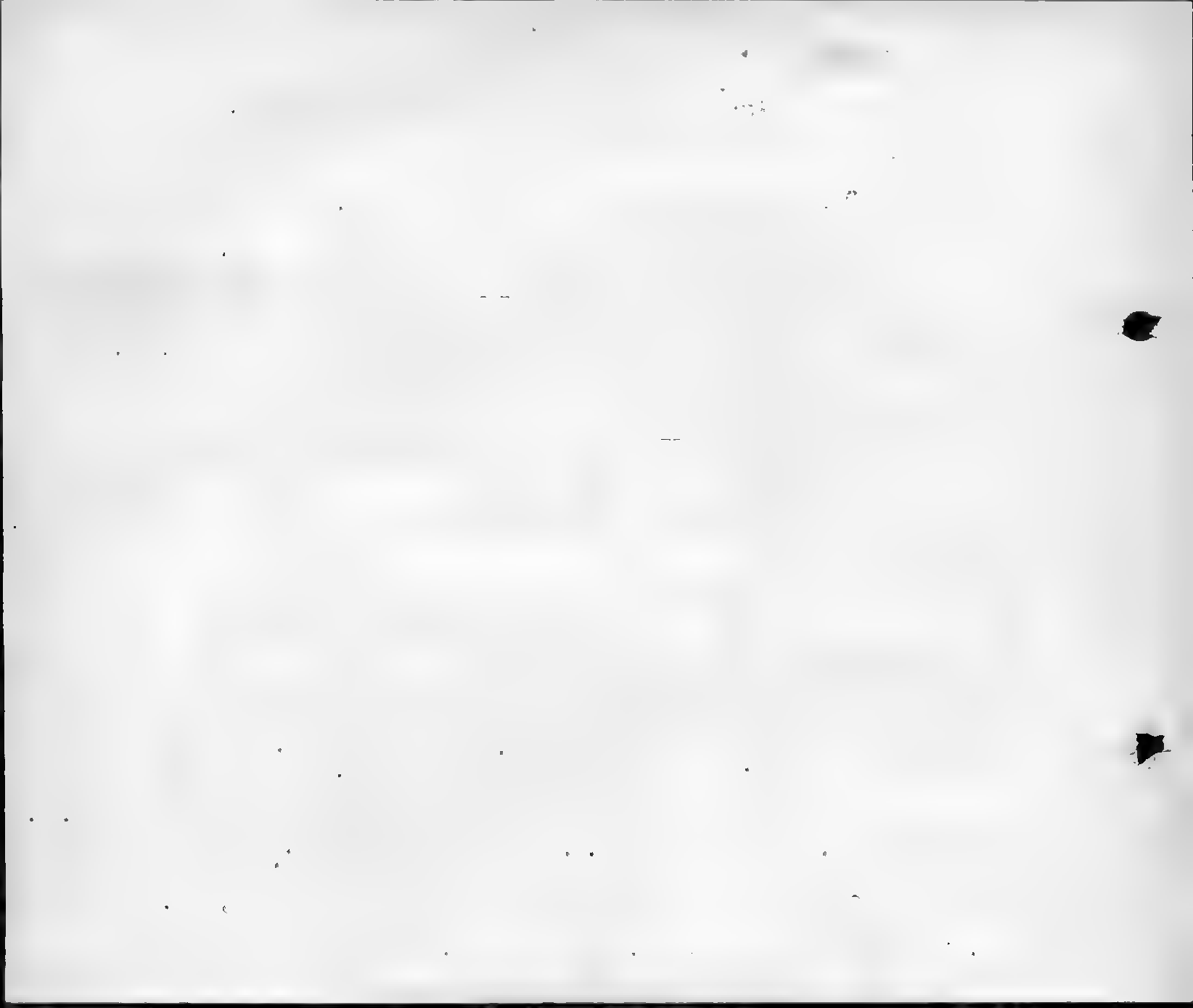
0227

1 PLACE OF DEATH a. COUNTY: <b>Prince George</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <b>Maryland</b> b. COUNTY: <b>Prince George</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>2 Days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General Hospital</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3 NAME OF DECEASED (Type or print) <b>Marie</b> First <b>G</b> Middle <b>Russell</b> Last			4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1961</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-9-91</b>		9. AGE (In years, months, days, hours, minutes) <b>89</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13 FATHER'S NAME <b>Henry Moore</b>		
14 MOTHER'S MAIDEN NAME <b>Anna Kelly</b>			15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>---</b>			17 INFORMANT <b>William Russell (Same as # 2)</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Emboli</b> DUE TO <b>Fracture of Left Humerus and Left Femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>					19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Patient fell at home</b>		
20c. TIME OF INJURY Month, Day, Year Hour <b>6:25</b> p.m. <b>Jan. 31 1961</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>in home</b>			20f. (City or town) (County) (State) <b>Marlow Hts. I.G. Md.</b>		
21 I certify that (I) (this hospital) attended the deceased from <b>Feb. 2</b> 19 <b>61</b> to <b>Feb. 5</b> 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>Feb. 5</b> 19 <b>61</b> , and that death occurred at <b>11:50 A.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <i>Wm. H. Holbrook</i>			22b. DATE SIGNED <b>Feb. 6, 1961</b>		
22c. PHYSICIAN'S NAME (Type) <b>Dr. William Holbrook, M.D.</b>			22d. ADDRESS <b>1500 College Ave. College Park, Md.</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/8/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
23d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>		24 FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>			
25a. REC'D BY REGISTRAR <b>DATE FEB 10 '61</b>		25b. REGISTRAR'S SIGNATURE <i>Chas. E. Kline</i>			

1

2

1

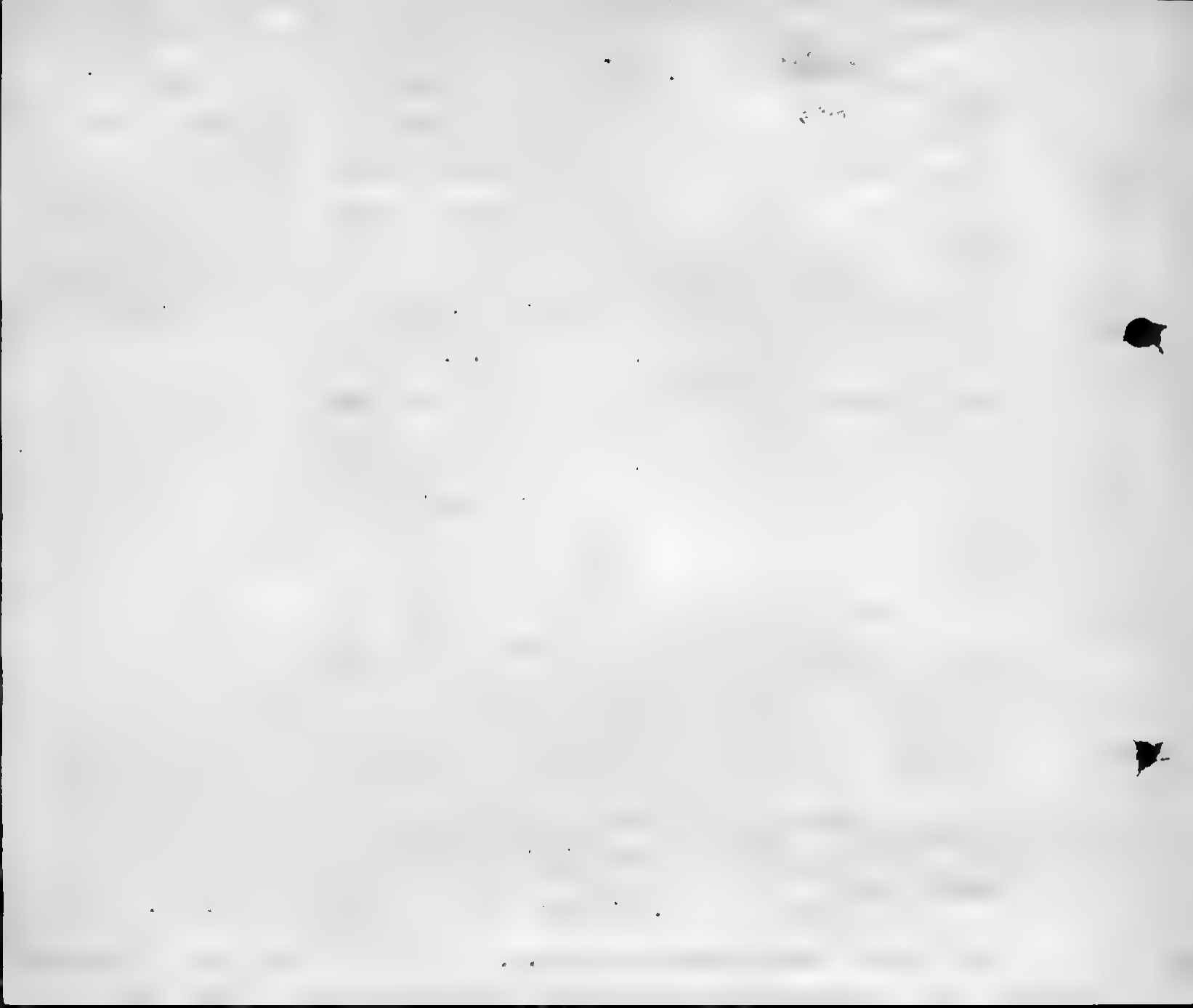


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

# 2300 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 02277

<b>1. PLACE OF DEATH</b> a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kent Village d. STREET ADDRESS 7343 Hawthorne st.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) Janice Anne Schlosser		<b>4. DATE OF DEATH</b> Feb 7 1961		
<b>5. SEX</b> Female	<b>6. COLOR OR RACE</b> White	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> Jan 18, 1961	<b>9. AGE</b> (In years last birthday) yrs. 20
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) D.C.
<b>12. CITIZEN OF WHAT COUNTRY?</b>				
<b>13. FATHER'S NAME</b> Leonard Schlosser		<b>14. MOTHER'S MAIDEN NAME</b> Eleanor Hitt		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Mrs Jeannette Nash 7343 Hawthorne S t.
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Meningitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Spina bifida</u> (c) <u>Exstrophy of spinal cord</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrocephalus</u>				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)		
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from 18 Jan 1961, to 7 Feb 1961, that (I) (we) last saw the deceased alive on 7 Feb 1961, and that death occurred at 7 Feb 1961, from the causes and on the date stated above.</b>				
<b>22a. SIGNATURE</b> Thomas G. Maloney M.D.		<b>22b. DATE SIGNED</b> 7 Feb 61		
<b>22c. PHYSICIAN'S NAME</b> (Type) THOMAS G. MALONEY		<b>22d. ADDRESS</b> 4814-71st Ave. HILLS MD.		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)	<b>23b. DATE THEREOF</b> 2-8-61	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Ft. Lincoln Cem.	<b>23d. LOCATION</b> (City, town or county) (State) Colmor Manor, Md.	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> Lee Funeral Home 300-4th Street N.E.		<b>25a. REC'D BY REGISTRAR</b> DATE FEB 10 '61		
		<b>25b. REGISTRAR'S SIGNATURE</b> Arthur S. Kraus		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

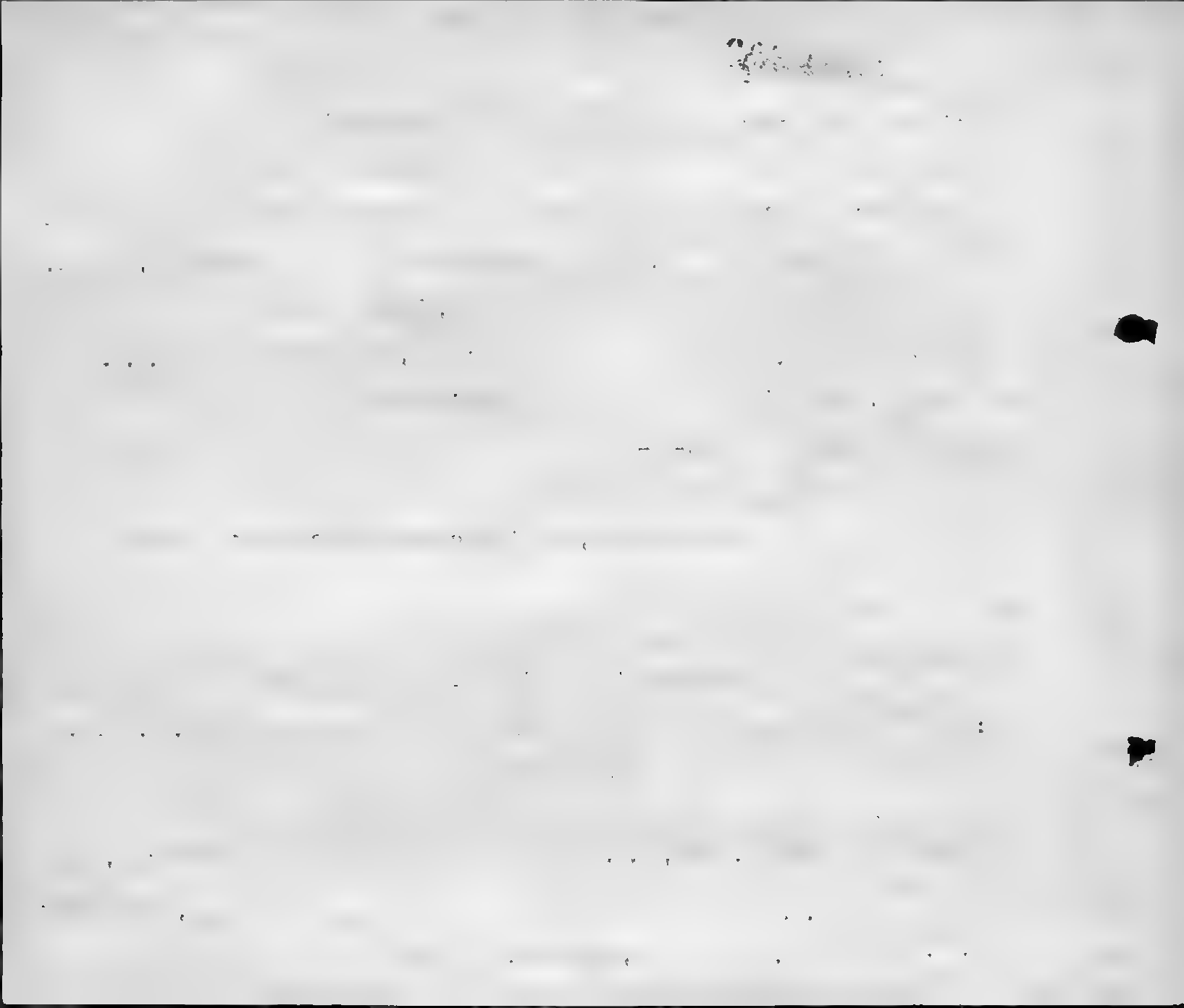
# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 2301 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02278

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>Lancaster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>534 Terrace Road</b>		d. STREET ADDRESS <b>534 Terrace Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>ROBERT B. SELDOMRIDGE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>2</b> Year <b>19 61.</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1892</b>		9. AGE (in years last birthday) <b>68</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bars</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert C. Seldomridge</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Sample</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>167-14-6427</b>							
17. INFORMANT <b>unknown</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> (b) <b>Crushed chest, multiple compound fractures of the legs</b> (c) <b>Crushed chest, multiple compound fractures of the legs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Passenger in a train that was in a wreck</b>		20a. EXTERNAL CAUSE WAS PR. MARYLAND or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in a train that was in a wreck</b>		20c. TIME OF INJURY Month, Day, Year <b>2/2/ 1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Train</b>		20f. (City or town) (County) (State) <b>Jerricho Park P. G. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lancaster</b>		22d. LOCATION (City, town, or country) (State) <b>Lancaster, Pennsylvania</b>		23. FUNERAL DIRECTOR <b>W. W. CHAMBERS CO., Riverdale, Maryland.</b>		24a. REC'D BY REGISTRAR <b>FEB 8 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25. CHIEF MEDICAL EXAMINER <b>JAMES I. BOYD, M.D.</b>		26. ASSISTANT MEDICAL EXAMINER <b>DATE SIGNED February 2, 1961</b>		27. DEPUTY MEDICAL EXAMINER <b>February 2, 1961</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, 17, 18, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

## CERTIFICATE OF DEATH

Reg. Dist. No.

02273

2302

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4825-BARRYMORE DRIVE OXON HILL</u>		d. STREET ADDRESS <u>4825-BARRYMORE DRIVE OXON HILL</u>	
3. NAME OF DECEASED (Type or print) <u>MARY ANDERSON SHALLCROSS</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23-1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES WOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WHEELING, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Clay Shallcross</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Shallcross (maiden name)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-07-0739</u>	
17. INFORMANT <u>KATHERINE A. SWEENEY</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular thrombosis</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO <u>  </u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic heart disease &amp; congestive heart failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/14/61</u> to <u>2/21/61</u> , that I last saw the deceased alive on <u>Feb. 20</u> , 19 <u>61</u> , and that death occurred at <u>8:00</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>101 ANDREY LANE</u> DATE SIGNED <u>2/21/61</u>			
ACTUAL SIGNATURE <u>Herbert Wisbisky</u> M.D.		PHYSICIAN'S NAME (Type) <u>HERBERT WISBISKY</u>	
22a. BURIAL, CREMATION, REMAINS (Specify) <u>2/24/61</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. G. Mallyng</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 24 '61</u>	
ADDRESS <u>131-11th St. S.E.</u>		24b. REGISTRAR'S SIGNATURE <u>Carling &amp; Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

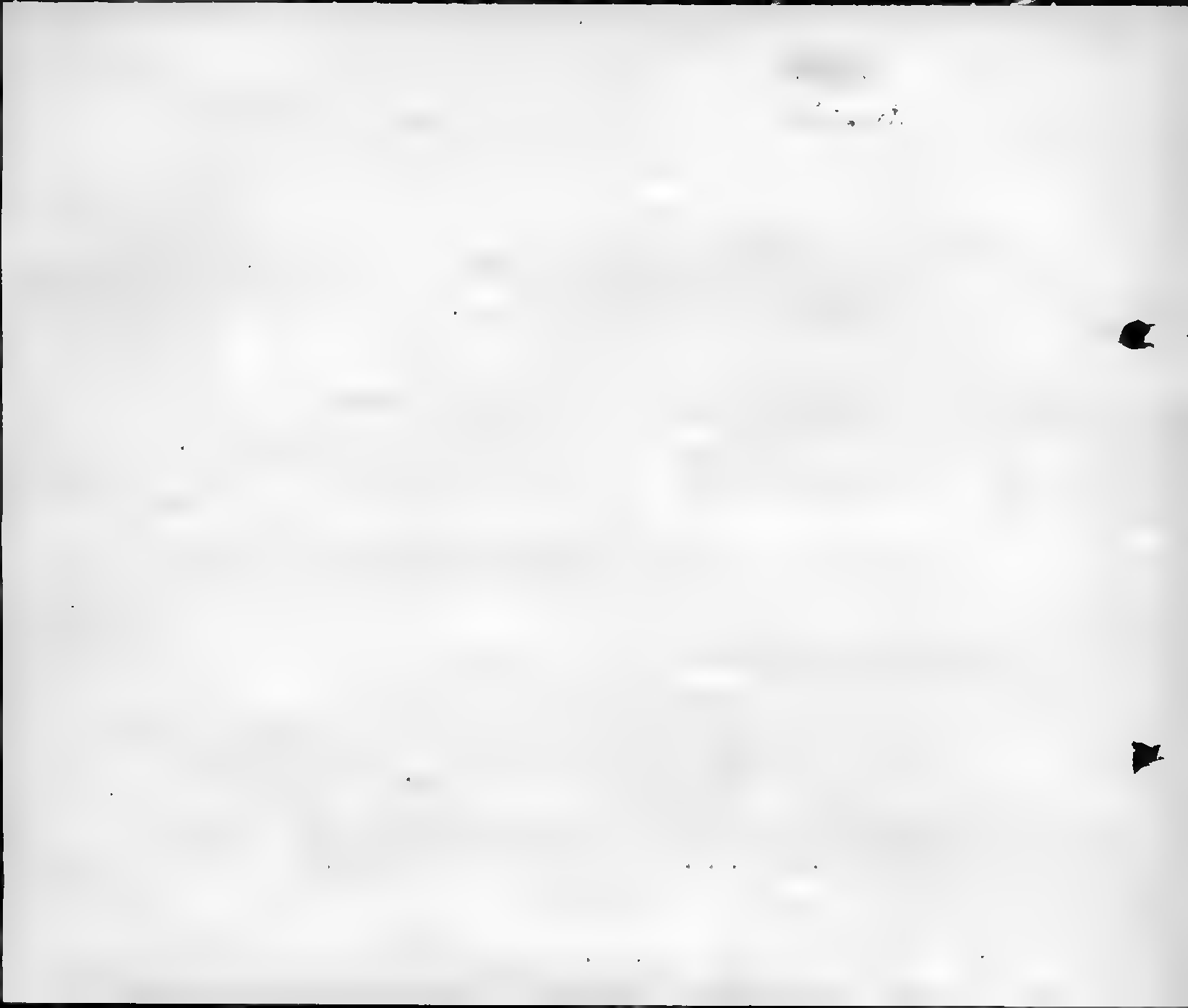
2303

Item 8 FLD 4201 2/23/61 mh

CERTIFICATE OF DEATH

022011

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Indiana</b> b. COUNTY <b>Randolph</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>20 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>Farmland</b>	
3. NAME OF DECEASED (Type or print) <b>Harriett Emma Shank</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>15</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1 Dec. 1888</b>
9. AGE (In years last birthday) <b>73</b> yrs		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>19</b> Hours <b>61</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School teacher</b>	
11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Rev John H Mc Arthur</b>		14. MOTHER'S MAIDEN NAME <b>? Turner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Martha L Cook</b>		Address <b>Seabrook Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Massive posterior Hemorrhage</b> <b>Arteriovenous Aneurysm</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June, 1952</b> , to <b>2/15, 1961</b> , that (I) (we) last saw the deceased alive on <b>2/15, 1961</b> , and that death occurred at <b>L. OGAN</b> from the causes and on the date stated above			
22a. SIGNATURE <b>Dr. F. Musser M.D.</b>		22b. DATE SIGNED <b>2/16/61</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>4410 74th Avenue Bellemeade, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transportation</b>		23b. DATE THEREOF <b>2/16/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Farmland</b>		23d. LOCATION (City, town, or county) (State) <b>Indiana</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>FEB 20 '61</b>	
ADDRESS <b>Hyattsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





100



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# 2305 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

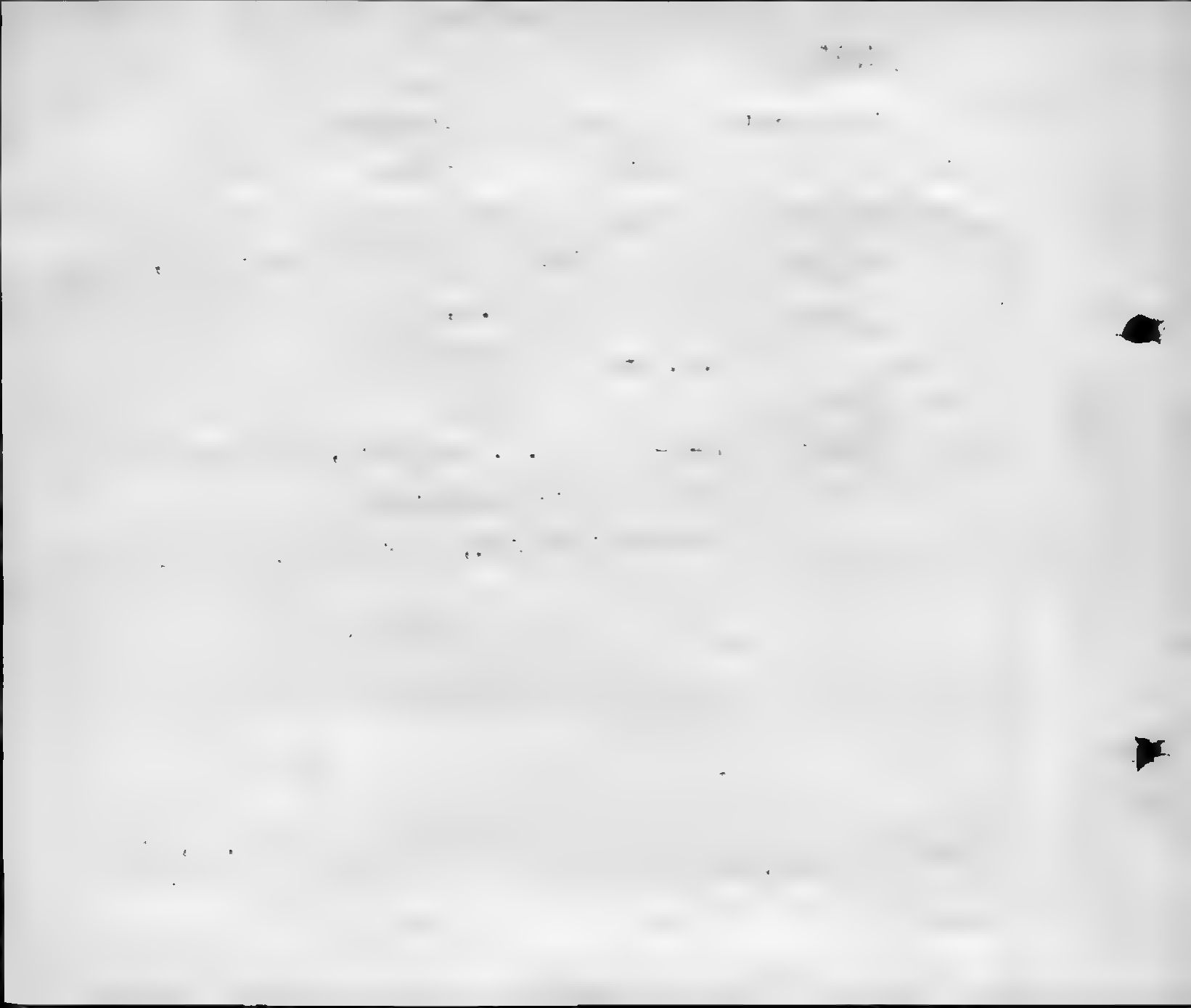
02282

1. PLACE OF DEATH • COUNTY <b>Prince George's</b> • CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bowie</b> • NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Bowie Race Track</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Everson</b> d. STREET ADDRESS <b>210 Brown Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>James Joseph</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb. 1, 1909</b>		9. AGE (In years last birthday) <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Jim Simon</b>		14. MOTHER'S MAIDEN NAME <b>Mary</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>178-07-1343</b>		17. INFORMANT <b>U. S. Army Records, Walter Reed</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO (b) <b>Coronary infarction., arteriosclerotic heart disease</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e.g., Autopsy performed at Walter Reed)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>Feb. 20, 1961</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 24 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SCOTSDALE P.</b>	
23. FUNERAL DIRECTOR <b>Riverside Funeral Home, Inc. 816 H St., N.E., Wash. D.C.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 23 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?  
YES ☒ NO ☐





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

2306

02283

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY IN 1b 24 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 600 Farragut St., N. W.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lena - Small				4. DATE OF DEATH Month 2 Day 19 Year 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/1884		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-- unknown				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Phillip E. Hart				14. MOTHER'S MAIDEN NAME Ella Thomas					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Decedent		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO (b) - Conditions, if any, which gave rise to immediate cause (c) DUE TO (c) Hypertensive and arteriosclerotic cardiovascular disease; volvulus, sigmoid, improved; colostomy 2/4/61 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1/26 to 2/19/1961, that (I) (we) last saw the deceased alive on 2/19/1961, and that death occurred at P.M. from the causes and on the date stated above.									
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED 2/19/61					
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial - Removal		23b. DATE THEREOF 2/20/61		23c. NAME OF CEMETERY OR CREMATORY TAYLOR CEMETERY		23d. LOCATION (City, town or county) (State) FREDERICKSBURG, VA.			
24. FUNERAL DIRECTOR'S SIGNATURE E. L. King				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 23 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

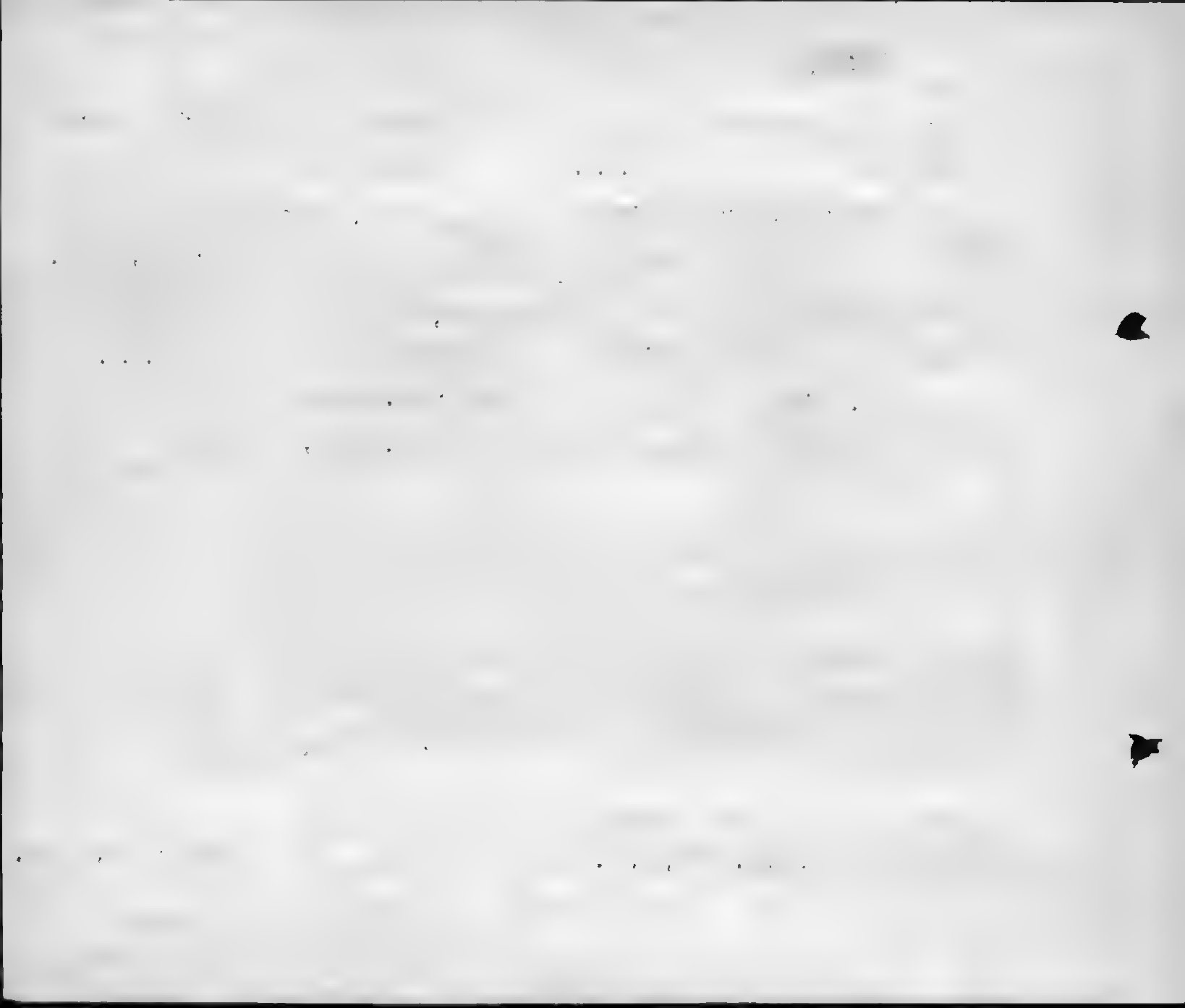


# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2307 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02206									
1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mitchellville</b>				
c. LENGTH OF STAY IN b. <b>D.O.A.</b>					d. STREET ADDRESS <b>Route #1, Box 3</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Prince Georges General Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>BRENDA</b> Middle <b>MARIE</b> Last <b>SMITH</b>					4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>1961</b>				
5. SEX <b>Female</b>					6. COLOR OR RACE <b>Negro</b>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <b>January 9, 1961</b>				
9. AGE (In years last birthday) <b>1</b> Months <b>14</b> Days <b>14</b>					10. IF UNDER 1 YEAR: Hours <b>1</b> Min. <b>14</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>				
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>					10d. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Raymond L. Smith</b>					14. MOTHER'S MAIDEN NAME <b>Margaret A. Jones</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>None</b>				
17. INFORMANT <b>Mrs Margaret A. Smith, Same as # 2</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>756.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7</b> DUE TO (c) <b>11</b>					INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>James I. Boyd</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M. D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-28-61</b>					22b. DATE THEREOF <b>1-28-61</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Italy Family</b>					22d. LOCATION (City, town, or country) (State) <b>Woodman Md</b>				
23. FUNERAL DIRECTOR <b>Honey Washington + Son</b>					24a. REC'D BY REGISTRAR <b>FEB 28 '61</b>				
ADDRESS <b>4925 Neane Ave 75</b>					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>				



FOR STATE  
HEALTH DEPT.

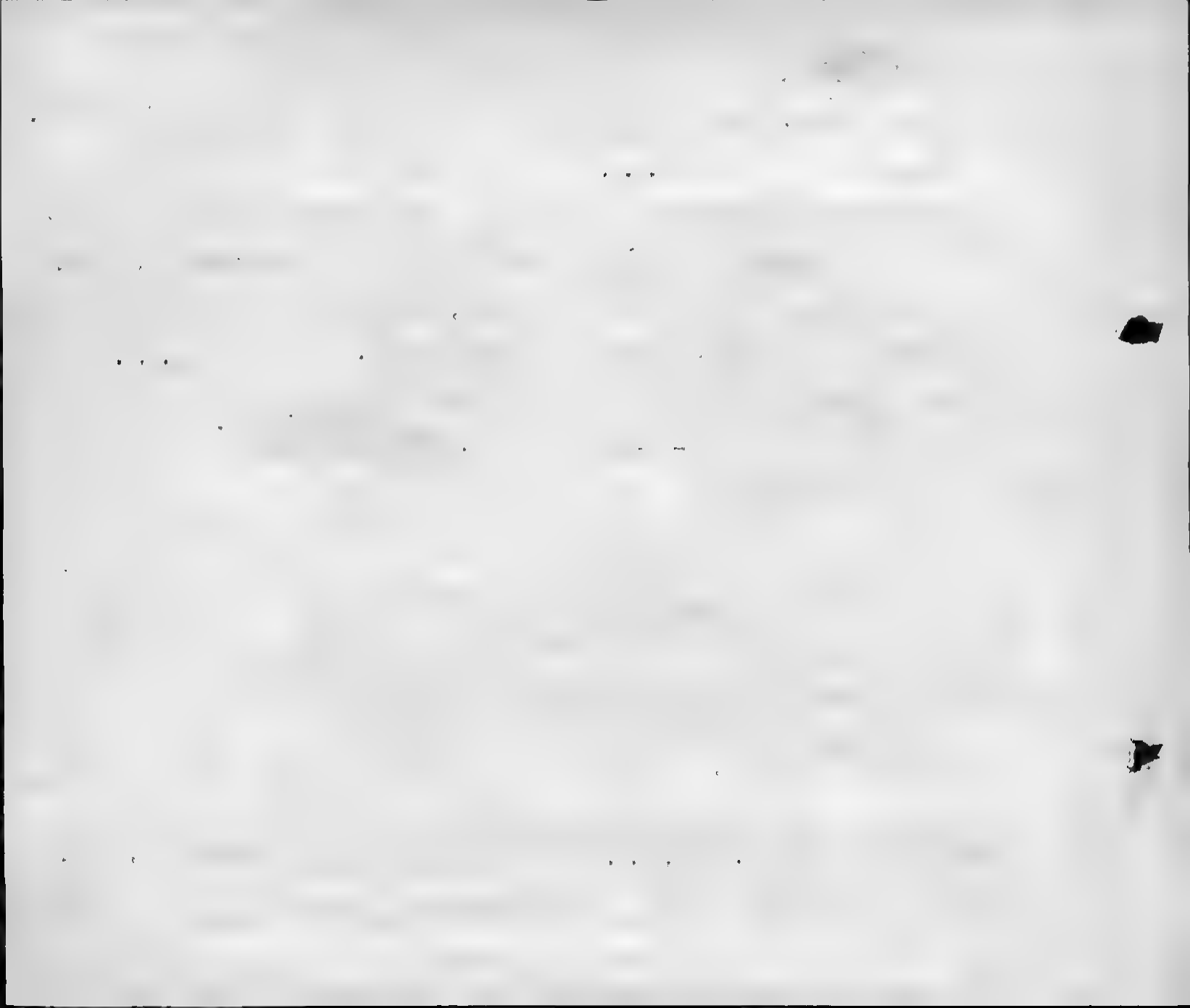
death. If any delay is necessary, and 3 to the funeral director. Page 5 may be retained for your files. TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MD  
2308 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN lb D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if not full-time residence before admission) a. STATE Maryland b. COUNTY Washington Cty. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 24 1/2 Franklin Street</p>			
<p>3. NAME OF DECEASED (Type or print) JOSEPH RICHARD SMITH First Middle Last</p>				<p>4. DATE OF DEATH February 26, 1961. Month Day Year</p>			
<p>5. SEX Male</p>		<p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH June 30, 1908 Yrs. Months Days Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY May's Hardware</p>		<p>11. BIRTHPLACE (State or foreign country) Funkstown Md.</p>	
<p>13. FATHER'S NAME Hiran L Smith</p>				<p>14. MOTHER'S MAIDEN NAME Margaret L Sly</p>			
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>				<p>16. SOCIAL SECURITY NO. 214-09-5027</p>		<p>17. INFORMANT 246 Fredrick St. Marvin W. Smith Hagerstown</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO (b) CORONARY ARTERY THROMBOSIS Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c)</p>						<p>INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.</p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.</p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED February 26, 1961.</p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>22b. DATE THEREOF 3/1/61</p>		<p>22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery</p>		<p>22d. LOCATION (City, town, or country) Hagerstown Md.</p>	
<p>23. FUNERAL DIRECTOR W. J. Hornum</p>				<p>24a. RECORD BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus</p>			

MAR 1 '61



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

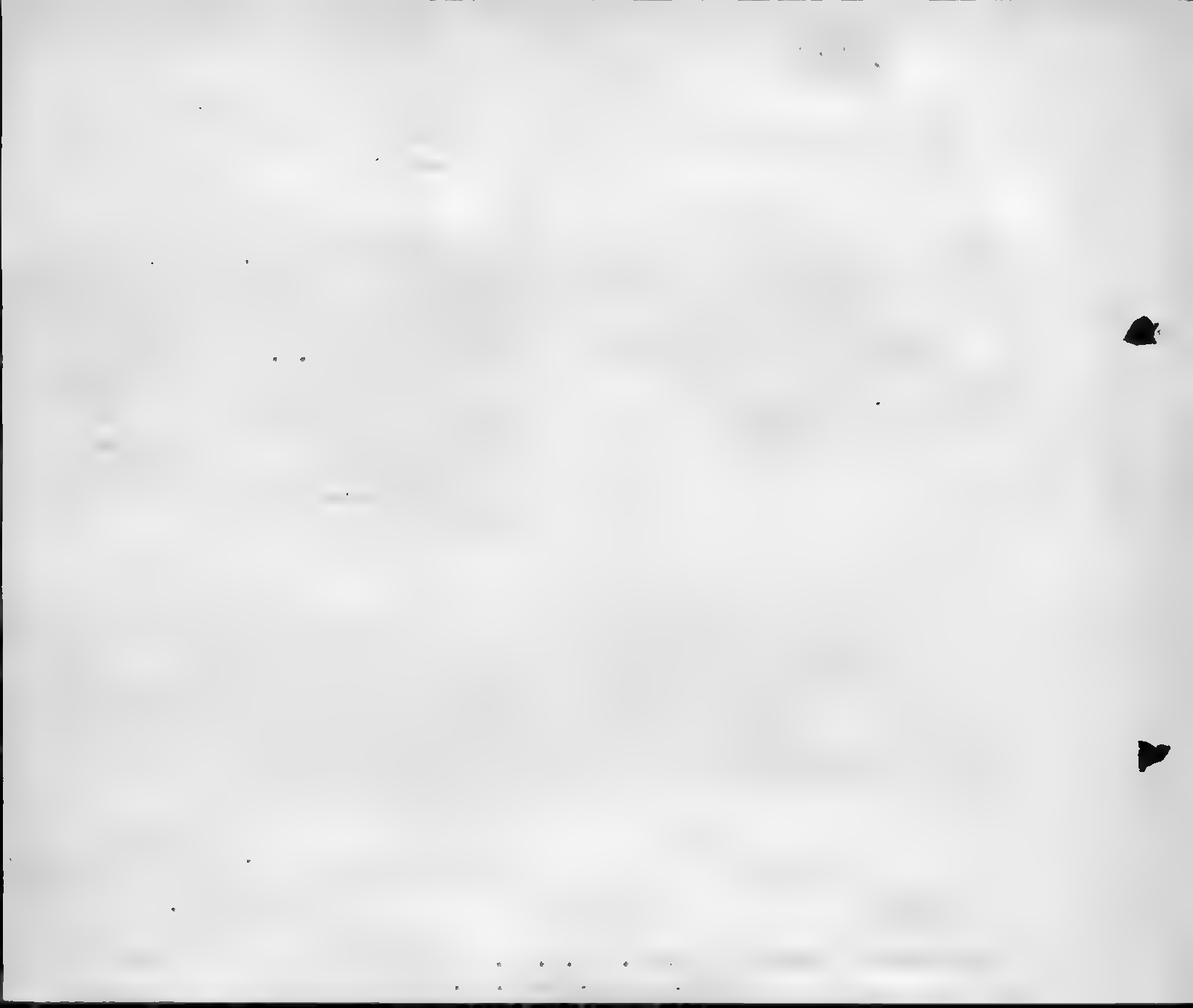
2309

02280

Item 1 Film 6280 2-6-61 et

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> c. LENGTH OF STAY IN 1b <b>Landover</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Columbia Park</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover</b> d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Vinton</b> Last <b>Sr</b> <b>S peiden</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/29/1906</b>	
9. AGE (In years last birthday) <b>54</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert V. S peiden</b>				14. MOTHER'S MAIDEN NAME <b>Mammie England</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs Helen Speiden Landover Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction, recent</b> DUE TO (b) <b>myocardial insufficiency</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>one day</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>61</b> , to <b>2/1</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on <b>1/28</b> , 19 <b>61</b> , and that death occurred at <b>2:30</b> p.m., from the causes and on the date stated above.							
22a. SIGNATURE <b>Barry Rosenberg</b>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type or print) <b>Barry Rosenberg</b>				22d. ADDRESS <b>5102 Annapolis Rd. Bladensburg, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE THEREOF <b>2-4-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 3 '61</b>			
ADDRESS <b>300 4th. st. N. E. Washington, 2, D. C.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





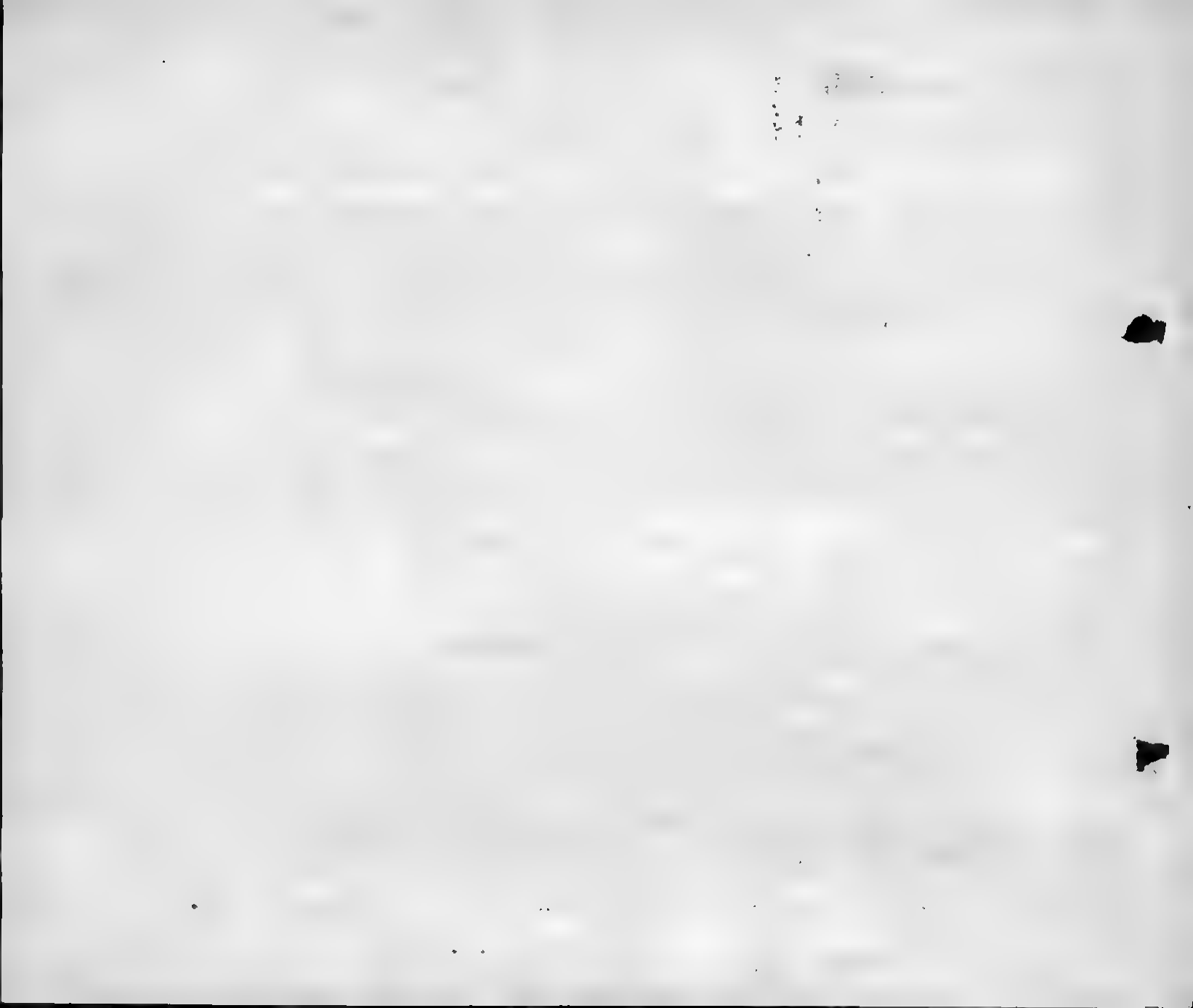
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>PRINCE GEORGE'S</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PRINCE GEORGE'S GENERAL HOSPITAL</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE'S</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 CHEVERLY</b> d. STREET ADDRESS <b>5729 LOCKWOOD ROAD</b>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>CLAIR</b>		<b>4. DATE OF DEATH</b> Month <b>FEB</b> Day <b>1</b> Year <b>1961</b>		<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>CAUCASIAN</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>DEC 31, 1894</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>GARAGE OWNER</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AUTO REPAIR</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>OHIO</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>a. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>13. FATHER'S NAME</b> <b>UNKNOWN</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>UNKNOWN</b>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>YES</b>				<b>17. INFORMANT</b> <b>MRS. DORIS S. FARR</b> Address <b>6804 99th AVE. SEABROOK, MD.</b>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Acute congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arterial heart disease</b> (c) <b>Left Bundle Branch Block</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
<b>ACTUAL SIGNATURE</b> <b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b> <b>2-1-61</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>2-4-61</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill</b>		<b>22d. LOCATION (City, town, or country)</b> (State) <b>Suitland Md.</b>			
<b>23. FUNERAL DIRECTOR</b> <b>Lee Funeral Home</b>				<b>ADDRESS</b> <b>Washington D.C.</b>				<b>24a. REC'D BY REG STRAR</b> <b>DATE FEB 3 '61</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION



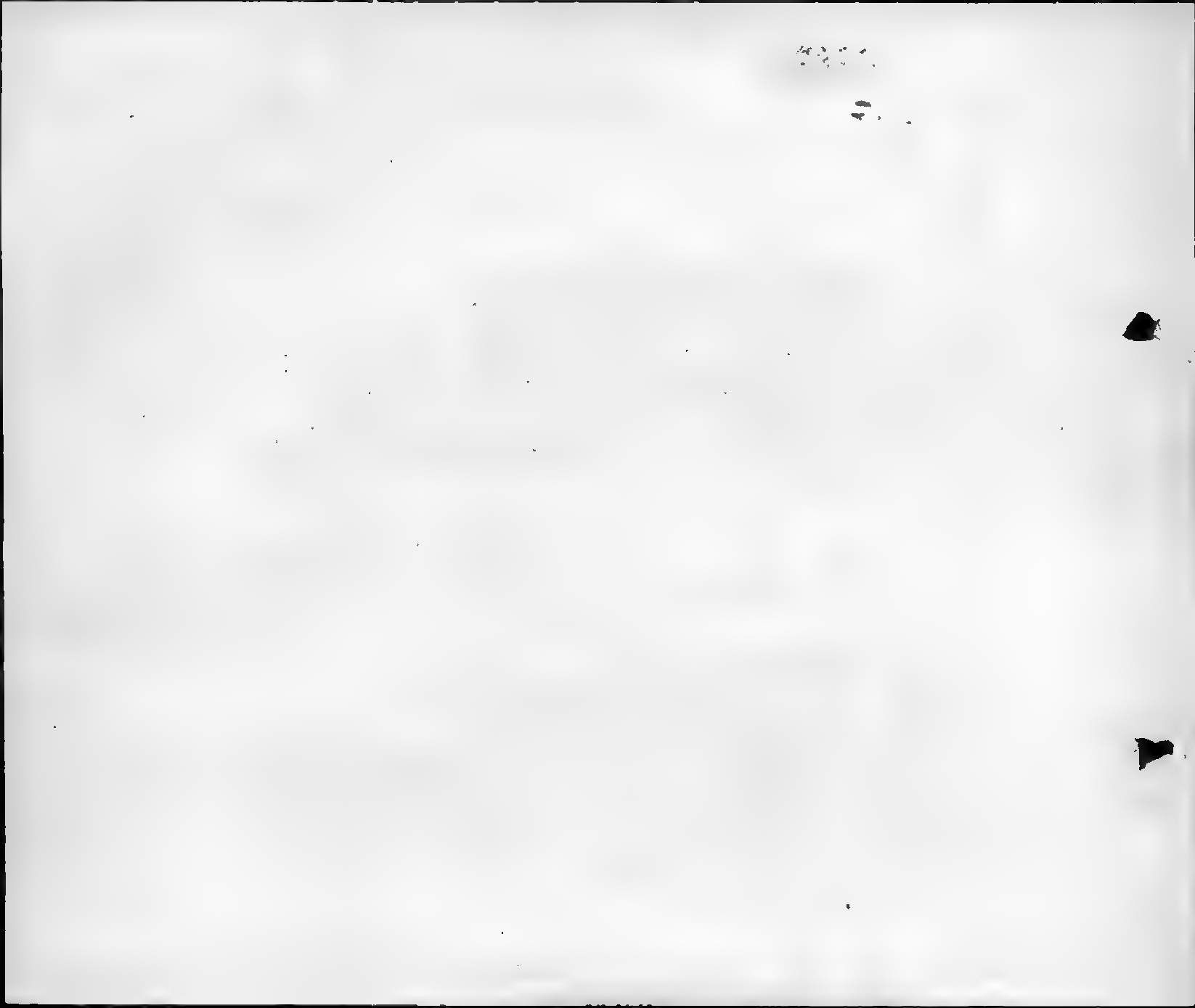
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2311

02288

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Prince George's</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George's</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier Md</u> d. STREET ADDRESS <u>3210 - Otis St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3 NAME OF DECEASED</b> (Type or print) First <u>Mollie</u> Middle <u>S.</u> Last <u>SWANN</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>28</u> Year <u>1961</u>			
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 6/75</u>	
<b>9. AGE</b> (In years last birthday) <u>86</u> yrs		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Lebanon Church, Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>William Coffelt</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Corbett</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Mrs. Charles B. Mikeoy, Sr.</u> Address <u>above</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]							
<b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <u>Massive Pulmonary Embolus</u>							
<b>903</b> DUE TO <u>Interochontic Fracture Left Hip</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. <u>  </u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)</b> <u>1. Hypertensive cardiovascular disease, 2. Diabetes mellitus</u>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in bathroom fracturing left hip</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11</u> <u>2-24</u> <u>1961</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
<b>20f. (City or town)</b> <u>Mt. Rainier Prince Georges Md.</u>				<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb. 24, 1961</u> <b>to</b> <u>Feb. 28, 1961</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb. 28, 1961</u> , <b>and that death occurred at</b> <u>10A</u> <b>M.</b> <b>from the causes and on the date stated above</b>							
<b>22a. SIGNATURE</b> <u>Waldo B. Moyers</u>				<b>22b. DATE SIGNED</b> <u>2-28-61</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Waldo B. Moyers</u>	
<b>22d. ADDRESS</b> <u>3503 Perry St. Mt. Rainier Md.</u>				<b>22e. M.D.</b> <input checked="" type="checkbox"/> <b>22f. MED. DIRECTOR</b> <input type="checkbox"/> <b>22g. STAFF PHYS.</b> <input type="checkbox"/>		<b>22h. DATE</b> <u>2-28-61</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/3/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedarwood Cemetery</u>		<b>23d. LOCATION</b> (City, town, or county) <u>Edinburg, Virginia</u> (State) <u>  </u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kalloy's Funeral Home</u>				<b>25a. REC'D BY REGISTRAR</b> <u>  </u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kuma</u>	
<b>25c. ADDRESS</b> <u>Mt. Rainier Md.</u>				<b>25d. DATE</b> <u>MAR 6 '61</u>		<b>25e. SIGNATURE</b> <u>  </u>	



2312

## CERTIFICATE OF DEATH

Reg. Dist. No.

02290

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>P. GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CLINTON</b>	
c. LENGTH OF STAY IN TB <b>6 yrs.</b>		d. STREET ADDRESS <b>7641 Kirby Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7641 Kirby Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GERTRUDE BERTHA THOMAS</b>		4. DATE OF DEATH <b>FEB. 25 1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 3<sup>rd</sup> 1908</b>
9. AGE (In years lost birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>2</b> Days <b>25</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>CLINTON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK GREEN</b>		14. MOTHER'S MAIDEN NAME <b>ESTELLA JACKSON.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-32-<del>XXXX</del> JOHN R. THOMAS</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL BRONCHOPNEUMONIA</b> DUE TO <b>GENERALIZED CARCINOMATOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>SQUAMOUS CELL CARCINOMA OF LARYNX.</b> (b) <b>9 MOS.</b> (c) <b>21 MOS.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 DAYS</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTR BUT NOT NG TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOT MEDICAL EXAMINER) <b>NONE</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>NONE</b> 19 <b>NONE</b>		20d. INJURY OCCURRED While at work <b>NONE</b> Not at work <b>NONE</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, high, etc.) <b>NONE</b>		20f. (City or town) (County) (State) <b>NONE</b>	
21. I certify that I attended the deceased from <b>APRIL 1957</b> to <b>PRESENT</b> , that I last saw the deceased alive on <b>FEB. 24, 1961</b> , and that death occurred at <b>10<sup>30</sup> PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur Shaver Jr. M.D.</b>		DATE SIGNED <b>2/25/61</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD.</b>		<b>2/25/61</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-1-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST JOHNS</b>		22d. LOCATION (City, town, or county) (State) <b>CLINTON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Md.</b>		ADDRESS <b>Waldorf, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 2 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Shaver</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1875  
The following is a list of the names of the persons who have been elected to the office of Justice of the Peace for the year 1875.  
The names are as follows:  
1. John A. Smith  
2. James B. Jones  
3. William C. Brown  
4. Charles D. White  
5. Edward F. Green  
6. George H. Black  
7. Henry I. Grey  
8. Thomas J. Pink  
9. Alexander K. Blue  
10. John L. Yellow  
11. Robert M. Purple  
12. David N. Brown  
13. John O. Green  
14. William P. Black  
15. James Q. Grey  
16. Charles R. Pink  
17. Edward S. Blue  
18. George T. Yellow  
19. Henry U. Purple  
20. Thomas V. Brown  
21. Alexander W. Green  
22. John X. Black  
23. Robert Y. Grey  
24. David Z. Pink  
25. John A. Blue  
26. William B. Yellow  
27. James C. Purple  
28. Charles D. Brown  
29. Edward E. Green  
30. George F. Black  
31. Henry G. Grey  
32. Thomas H. Pink  
33. Alexander I. Blue  
34. John J. Yellow  
35. Robert K. Purple  
36. David L. Brown  
37. John M. Green  
38. William N. Black  
39. James O. Grey  
40. Charles P. Pink  
41. Edward Q. Blue  
42. George R. Yellow  
43. Henry S. Purple  
44. Thomas T. Brown  
45. Alexander U. Green  
46. John V. Black  
47. Robert W. Grey  
48. David X. Pink  
49. John Y. Blue  
50. William Z. Yellow  
51. James A. Purple  
52. Charles B. Brown  
53. Edward C. Green  
54. George D. Black  
55. Henry E. Grey  
56. Thomas F. Pink  
57. Alexander G. Blue  
58. John H. Yellow  
59. Robert I. Purple  
60. David J. Brown  
61. John K. Green  
62. William L. Black  
63. James M. Grey  
64. Charles N. Pink  
65. Edward O. Blue  
66. George P. Yellow  
67. Henry Q. Purple  
68. Thomas R. Brown  
69. Alexander S. Green  
70. John T. Black  
71. Robert U. Grey  
72. David V. Pink  
73. John W. Blue  
74. William X. Yellow  
75. James Y. Purple  
76. Charles Z. Brown  
77. Edward A. Green  
78. George B. Black  
79. Henry C. Grey  
80. Thomas D. Pink  
81. Alexander E. Blue  
82. John F. Yellow  
83. Robert G. Purple  
84. David H. Brown  
85. John I. Green  
86. William J. Black  
87. James K. Grey  
88. Charles L. Pink  
89. Edward M. Blue  
90. George N. Yellow  
91. Henry O. Purple  
92. Thomas P. Brown  
93. Alexander Q. Green  
94. John R. Black  
95. Robert S. Grey  
96. David T. Pink  
97. John U. Blue  
98. William V. Yellow  
99. James W. Purple  
100. Charles X. Brown  
101. Edward Y. Green  
102. George Z. Black  
103. Henry A. Grey  
104. Thomas B. Pink  
105. Alexander C. Blue  
106. John D. Yellow  
107. Robert E. Purple  
108. David F. Brown  
109. John G. Green  
110. William H. Black  
111. James I. Grey  
112. Charles J. Pink  
113. Edward K. Blue  
114. George L. Yellow  
115. Henry M. Purple  
116. Thomas N. Brown  
117. Alexander O. Green  
118. John P. Black  
119. Robert Q. Grey  
120. David R. Pink  
121. John S. Blue  
122. William T. Yellow  
123. James U. Purple  
124. Charles V. Brown  
125. Edward W. Green  
126. George X. Black  
127. Henry Y. Grey  
128. Thomas Z. Pink  
129. Alexander A. Blue  
130. John B. Yellow  
131. Robert C. Purple  
132. David D. Brown  
133. John E. Green  
134. William F. Black  
135. James G. Grey  
136. Charles H. Pink  
137. Edward I. Blue  
138. George J. Yellow  
139. Henry K. Purple  
140. Thomas L. Brown  
141. Alexander M. Green  
142. John N. Black  
143. Robert O. Grey  
144. David P. Pink  
145. John Q. Blue  
146. William R. Yellow  
147. James S. Purple  
148. Charles T. Brown  
149. Edward U. Green  
150. George V. Black  
151. Henry W. Grey  
152. Thomas X. Pink  
153. Alexander Y. Blue  
154. John Z. Yellow  
155. Robert A. Purple  
156. David B. Brown  
157. John C. Green  
158. William D. Black  
159. James E. Grey  
160. Charles F. Pink  
161. Edward G. Blue  
162. George H. Yellow  
163. Henry I. Purple  
164. Thomas J. Brown  
165. Alexander K. Green  
166. John L. Black  
167. Robert M. Grey  
168. David N. Pink  
169. John O. Blue  
170. William P. Yellow  
171. James Q. Purple  
172. Charles R. Brown  
173. Edward S. Green  
174. George T. Black  
175. Henry U. Grey  
176. Thomas V. Pink  
177. Alexander W. Blue  
178. John X. Yellow  
179. Robert Y. Purple  
180. David Z. Brown  
181. John A. Green  
182. William B. Black  
183. James C. Grey  
184. Charles D. Pink  
185. Edward E. Blue  
186. George F. Yellow  
187. Henry G. Purple  
188. Thomas H. Brown  
189. Alexander I. Green  
190. John J. Black  
191. Robert K. Grey  
192. David L. Pink  
193. John M. Blue  
194. William N. Yellow  
195. James O. Purple  
196. Charles P. Brown  
197. Edward Q. Green  
198. George R. Black  
199. Henry S. Grey  
200. Thomas T. Pink  
201. Alexander U. Blue  
202. John V. Yellow  
203. Robert W. Purple  
204. David X. Brown  
205. John Y. Green  
206. William Z. Black  
207. James A. Grey  
208. Charles B. Pink  
209. Edward C. Blue  
210. George D. Yellow  
211. Henry E. Purple  
212. Thomas F. Brown  
213. Alexander G. Green  
214. John H. Black  
215. Robert I. Grey  
216. David J. Pink  
217. John K. Blue  
218. William L. Yellow  
219. James M. Purple  
220. Charles N. Brown  
221. Edward O. Green  
222. George P. Black  
223. Henry Q. Grey  
224. Thomas R. Pink  
225. Alexander S. Blue  
226. John T. Yellow  
227. Robert U. Purple  
228. David V. Brown  
229. John W. Green  
230. William X. Black  
231. James Y. Grey  
232. Charles Z. Pink  
233. Edward A. Blue  
234. George B. Yellow  
235. Henry C. Purple  
236. Thomas D. Brown  
237. Alexander E. Green  
238. John F. Black  
239. Robert G. Grey  
240. David H. Pink  
241. John I. Blue  
242. William J. Yellow  
243. James K. Purple  
244. Charles L. Brown  
245. Edward M. Green  
246. George N. Black  
247. Henry O. Grey  
248. Thomas P. Pink  
249. Alexander Q. Blue  
250. John R. Yellow  
251. Robert S. Purple  
252. David T. Brown  
253. John U. Green  
254. William V. Black  
255. James W. Grey  
256. Charles X. Pink  
257. Edward Y. Blue  
258. George Z. Yellow  
259. Henry A. Purple  
260. Thomas B. Brown  
261. Alexander C. Green  
262. John D. Black  
263. Robert E. Grey  
264. David F. Pink  
265. John G. Blue  
266. William H. Yellow  
267. James I. Purple  
268. Charles J. Brown  
269. Edward K. Green  
270. George L. Black  
271. Henry M. Grey  
272. Thomas N. Pink  
273. Alexander O. Blue  
274. John P. Yellow  
275. Robert Q. Purple  
276. David R. Brown  
277. John S. Green  
278. William T. Black  
279. James U. Grey  
280. Charles V. Pink  
281. Edward W. Blue  
282. George X. Yellow  
283. Henry Y. Purple  
284. Thomas Z. Brown  
285. Alexander A. Green  
286. John B. Black  
287. Robert C. Grey  
288. David D. Pink  
289. John E. Blue  
290. William F. Yellow  
291. James G. Purple  
292. Charles H. Brown  
293. Edward I. Green  
294. George J. Black  
295. Henry K. Grey  
296. Thomas L. Pink  
297. Alexander M. Blue  
298. John N. Yellow  
299. Robert O. Purple  
300. David P. Brown  
301. John Q. Green  
302. William R. Black  
303. James S. Grey  
304. Charles T. Pink  
305. Edward U. Blue  
306. George V. Yellow  
307. Henry W. Purple  
308. Thomas X. Brown  
309. Alexander Y. Green  
310. John Z. Black  
311. Robert A. Grey  
312. David B. Pink  
313. John C. Blue  
314. William D. Yellow  
315. James E. Purple  
316. Charles F. Brown  
317. Edward G. Green  
318. George H. Black  
319. Henry I. Grey  
320. Thomas J. Pink  
321. Alexander K. Blue  
322. John L. Yellow  
323. Robert M. Purple  
324. David N. Brown  
325. John O. Green  
326. William P. Black  
327. James Q. Grey  
328. Charles R. Pink  
329. Edward S. Blue  
330. George T. Yellow  
331. Henry U. Purple  
332. Thomas V. Brown  
333. Alexander W. Green  
334. John X. Black  
335. Robert Y. Grey  
336. David Z. Pink  
337. John A. Blue  
338. William B. Yellow  
339. James C. Purple  
340. Charles D. Brown  
341. Edward E. Green  
342. George F. Black  
343. Henry G. Grey  
344. Thomas H. Pink  
345. Alexander I. Blue  
346. John J. Yellow  
347. Robert K. Purple  
348. David L. Brown  
349. John M. Green  
350. William N. Black  
351. James O. Grey  
352. Charles P. Pink  
353. Edward Q. Blue  
354. George R. Yellow  
355. Henry S. Purple  
356. Thomas T. Brown  
357. Alexander U. Green  
358. John V. Black  
359. Robert W. Grey  
360. David X. Pink  
361. John Y. Blue  
362. William Z. Yellow  
363. James A. Purple  
364. Charles B. Brown  
365. Edward C. Green  
366. George D. Black  
367. Henry E. Grey  
368. Thomas F. Pink  
369. Alexander G. Blue  
370. John H. Yellow  
371. Robert I. Purple  
372. David J. Brown  
373. John K. Green  
374. William L. Black  
375. James M. Grey  
376. Charles N. Pink  
377. Edward O. Blue  
378. George P. Yellow  
379. Henry Q. Purple  
380. Thomas R. Brown  
381. Alexander S. Green  
382. John T. Black  
383. Robert U. Grey  
384. David V. Pink  
385. John W. Blue  
386. William X. Yellow  
387. James Y. Purple  
388. Charles Z. Brown  
389. Edward A. Green  
390. George B. Black  
391. Henry C. Grey  
392. Thomas D. Pink  
393. Alexander E. Blue  
394. John F. Yellow  
395. Robert G. Purple  
396. David H. Brown  
397. John I. Green  
398. William J. Black  
399. James K. Grey  
400. Charles L. Pink  
401. Edward M. Blue  
402. George N. Yellow  
403. Henry O. Purple  
404. Thomas P. Brown  
405. Alexander Q. Green  
406. John R. Black  
407. Robert S. Grey  
408. David T. Pink  
409. John U. Blue  
410. William V. Yellow  
411. James W. Purple  
412. Charles X. Brown  
413. Edward Y. Green  
414. George Z. Black  
415. Henry A. Grey  
416. Thomas B. Pink  
417. Alexander C. Blue  
418. John D. Yellow  
419. Robert E. Purple  
420. David F. Brown  
421. John G. Green  
422. William H. Black  
423. James I. Grey  
424. Charles J. Pink  
425. Edward K. Blue  
426. George L. Yellow  
427. Henry M. Purple  
428. Thomas N. Brown  
429. Alexander O. Green  
430. John P. Black  
431. Robert Q. Grey  
432. David R. Pink  
433. John S. Blue  
434. William T. Yellow  
435. James U. Purple  
436. Charles V. Brown  
437. Edward W. Green  
438. George X. Black  
439. Henry Y. Grey  
440. Thomas Z. Pink  
441. Alexander A. Blue  
442. John B. Yellow  
443. Robert C. Purple  
444. David D. Brown  
445. John E. Green  
446. William F. Black  
447. James G. Grey  
448. Charles H. Pink  
449. Edward I. Blue  
450. George J. Yellow  
451. Henry K. Purple  
452. Thomas L. Brown  
453. Alexander M. Green  
454. John N. Black  
455. Robert O. Grey  
456. David P. Pink  
457. John Q. Blue  
458. William R. Yellow  
459. James S. Purple  
460. Charles T. Brown  
461. Edward U. Green  
462. George V. Black  
463. Henry W. Grey  
464. Thomas X. Pink  
465. Alexander Y. Blue  
466. John Z. Yellow  
467. Robert A. Purple  
468. David B. Brown  
469. John C. Green  
470. William D. Black  
471. James E. Grey  
472. Charles F. Pink  
473. Edward G. Blue  
474. George H. Yellow  
475. Henry I. Purple  
476. Thomas J. Brown  
477. Alexander K. Green  
478. John L. Black  
479. Robert M. Grey  
480. David N. Pink  
481. John O. Blue  
482. William P. Yellow  
483. James Q. Purple  
484. Charles R. Brown  
485. Edward S. Green  
486. George T. Black  
487. Henry U. Grey  
488. Thomas V. Pink  
489. Alexander W. Blue  
490. John X. Yellow  
491. Robert Y. Purple  
492. David Z. Brown  
493. John A. Green  
494. William B. Black  
495. James C. Grey  
496. Charles D. Pink  
497. Edward E. Blue  
498. George F. Yellow  
499. Henry G. Purple  
500. Thomas H. Brown  
501. Alexander I. Green  
502. John J. Black  
503. Robert K. Grey  
504. David L. Pink  
505. John M. Blue  
506. William N. Yellow  
507. James O. Purple  
508. Charles P. Brown  
509. Edward Q. Green  
510. George R. Black  
511. Henry S. Grey  
512. Thomas T. Pink  
513. Alexander U. Blue  
514. John V. Yellow  
515. Robert W. Purple  
516. David X. Brown  
517. John Y. Green  
518. William Z. Black  
519. James A. Grey  
520. Charles B. Pink  
521. Edward C. Blue  
522. George D. Yellow  
523. Henry E. Purple  
524. Thomas F. Brown  
525. Alexander G. Green  
526. John H. Black  
527. Robert I. Grey  
528. David J. Pink  
529. John K. Blue  
530. William L. Yellow  
531. James M. Purple  
532. Charles N. Brown  
533. Edward O. Green  
534. George P. Black  
535. Henry Q. Grey  
536. Thomas R. Pink  
537. Alexander S. Blue  
538. John T. Yellow  
539. Robert U. Purple  
540. David V. Brown  
541. John W. Green  
542. William X. Black  
543. James Y. Grey  
544. Charles Z. Pink  
545. Edward A. Blue  
546. George B. Yellow  
547. Henry C. Purple  
548. Thomas D. Brown  
549. Alexander E. Green  
550. John F. Black  
551. Robert G. Grey  
552. David H. Pink  
553. John I. Blue  
554. William J. Yellow  
555. James K. Purple  
556. Charles L. Brown  
557. Edward M. Green  
558. George N. Black  
559. Henry O. Grey  
560. Thomas P. Pink  
561. Alexander Q. Blue  
562. John R. Yellow  
563. Robert S. Purple  
564. David T. Brown  
565. John U. Green  
566. William V. Black  
567. James W. Grey  
568. Charles X. Pink  
569. Edward Y. Blue  
570. George Z. Yellow  
571. Henry A. Purple  
572. Thomas B. Brown  
573. Alexander C. Green  
574. John D. Black  
575. Robert E. Grey  
576. David F. Pink  
577. John G. Blue  
578. William H. Yellow  
579. James I. Purple  
580. Charles J. Brown  
581. Edward K. Green  
582. George L. Black  
583. Henry M. Grey  
584. Thomas N. Pink  
585. Alexander O. Blue  
586. John P. Yellow  
587. Robert Q. Purple  
588. David R. Brown  
589. John S. Green  
590. William T. Black  
591. James U. Grey  
592. Charles V. Pink  
593. Edward W. Blue  
594. George X. Yellow  
595. Henry Y. Purple  
596. Thomas Z. Brown  
597. Alexander A. Green  
598. John B. Black  
599. Robert C. Grey  
600. David D. Pink  
601. John E. Blue  
602. William F. Yellow  
603. James G. Purple  
604. Charles H. Brown  
605. Edward I. Green  
606. George J. Black  
607. Henry K. Grey  
608. Thomas L. Pink  
609. Alexander M. Blue  
610. John N. Yellow  
611. Robert O. Purple  
612. David P. Brown  
613. John Q. Green  
614. William R. Black  
615. James S. Grey  
616. Charles T. Pink  
617. Edward U. Blue  
618. George V. Yellow  
619. Henry W. Purple  
620. Thomas X. Brown  
621. Alexander Y. Green  
622. John Z. Black  
623. Robert A. Grey  
624. David B. Pink  
625. John C. Blue  
626. William D. Yellow  
627. James E. Purple  
628. Charles F. Brown  
629. Edward G. Green  
630. George H. Black  
631. Henry I. Grey  
632. Thomas J. Pink  
633. Alexander K. Blue  
634. John L. Yellow  
635. Robert M. Purple  
636. David N. Brown  
637. John O. Green  
638. William P. Black  
639. James Q. Grey  
640. Charles R. Pink  
641. Edward S. Blue  
642. George T. Yellow  
643. Henry U. Purple  
644. Thomas V. Brown  
645. Alexander W. Green  
646. John X. Black  
647. Robert Y. Grey  
648. David Z. Pink  
649. John A. Blue  
650. William B. Yellow  
651. James C. Purple  
652. Charles D. Brown  
653. Edward E. Green  
654. George F. Black  
655. Henry G. Grey  
656. Thomas H. Pink  
657. Alexander I. Blue  
658. John J. Yellow  
659. Robert K. Purple  
660. David L. Brown  
661. John M. Green  
662. William N. Black  
663. James O. Grey  
664. Charles P. Pink  
665. Edward Q. Blue  
666. George R. Yellow  
667. Henry S. Purple  
668. Thomas T. Brown  
669. Alexander U. Green  
670. John V. Black  
671. Robert W. Grey  
672. David X. Pink  
673. John Y. Blue  
674. William Z. Yellow  
675. James A. Purple  
676. Charles B. Brown  
677. Edward C. Green  
678. George D. Black  
679. Henry E. Grey  
680. Thomas F. Pink  
681. Alexander G. Blue  
682. John H. Yellow  
683. Robert I. Purple  
684. David J. Brown  
685. John K. Green  
686. William L. Black  
687. James M. Grey  
688. Charles N. Pink  
689. Edward O. Blue  
690. George P. Yellow  
691. Henry Q. Purple  
692. Thomas R. Brown  
693. Alexander S. Green  
694. John T. Black  
695. Robert U. Grey  
696. David V. Pink  
697. John W. Blue  
698. William X. Yellow  
699. James Y. Purple  
700. Charles Z. Brown  
701. Edward A. Green  
702. George B. Black  
703. Henry C. Grey  
704. Thomas D. Pink  
705. Alexander E. Blue  
706. John F. Yellow  
707. Robert G. Purple  
708. David H. Brown  
709. John I. Green  
710. William J. Black  
711. James K. Grey  
712. Charles L. Pink  
713. Edward M. Blue  
714. George N. Yellow  
715. Henry O. Purple  
716. Thomas P. Brown  
717. Alexander Q. Green  
718. John R. Black  
719. Robert S. Grey  
720. David T. Pink  
721. John U. Blue  
722. William V. Yellow  
723. James W. Purple  
724. Charles X. Brown  
725. Edward Y. Green  
726. George Z. Black  
727. Henry A. Grey  
728. Thomas B. Pink  
729. Alexander C. Blue  
730. John D. Yellow  
731. Robert E. Purple  
732. David F. Brown  
733. John G. Green  
734. William H. Black  
735. James I. Grey  
736. Charles J. Pink  
737. Edward K. Blue  
738. George L. Yellow  
739. Henry M. Purple  
740. Thomas N. Brown  
741. Alexander O. Green  
742. John P. Black  
743. Robert Q. Grey  
744. David R. Pink  
745. John S. Blue  
746. William T. Yellow  
747. James U. Purple  
748. Charles V. Brown  
749. Edward W. Green  
750. George X. Black  
751. Henry Y. Grey  
752. Thomas Z. Pink  
753. Alexander A. Blue  
754. John B. Yellow  
755. Robert C. Purple  
756. David D. Brown  
757. John E. Green  
758. William F. Black  
759. James G. Grey  
760. Charles H. Pink  
761. Edward I. Blue  
762. George J. Yellow  
763. Henry K. Purple  
764. Thomas L. Brown  
765. Alexander M. Green  
766. John N. Black  
767. Robert O. Grey  
768. David P. Pink  
769. John Q. Blue  
770. William R. Yellow  
771. James S. Purple  
772. Charles T. Brown  
773. Edward U. Green  
774. George V. Black  
775. Henry W. Grey  
776. Thomas X. Pink  
777. Alexander Y. Blue  
778. John Z. Yellow  
779. Robert A. Purple  
780. David B. Brown  
781. John C. Green  
782. William D. Black  
783. James E. Grey  
784. Charles F. Pink  
785. Edward G. Blue  
786. George H. Yellow  
787. Henry I. Purple  
788. Thomas J. Brown  
789. Alexander K. Green  
790. John L. Black  
791. Robert M. Grey  
792. David N. Pink  
793. John O. Blue  
794. William P. Yellow  
795. James Q. Purple  
796. Charles R. Brown  
797. Edward S. Green  
798. George T. Black  
799. Henry U. Grey  
800. Thomas V. Pink  
801. Alexander W. Blue  
802. John X. Yellow  
803. Robert Y. Purple  
804. David Z. Brown  
805. John A. Green  
806. William B. Black  
807. James C. Grey  
808. Charles D. Pink  
809. Edward E. Blue  
810. George F. Yellow  
811. Henry G. Purple  
812. Thomas H. Brown  
813. Alexander I. Green  
814. John J. Black  
815. Robert K. Grey  
816. David L. Pink  
817. John M. Blue  
818. William N. Yellow  
819. James O. Purple  
820. Charles P. Brown  
821. Edward Q. Green  
822. George R. Black  
823. Henry S. Grey  
824. Thomas T. Pink  
825. Alexander U. Blue  
826. John V. Yellow  
827. Robert W. Purple  
828. David X. Brown  
829. John Y. Green  
830. William Z. Black  
831. James A. Grey  
832. Charles B. Pink  
833. Edward C. Blue  
834. George D. Yellow  
835. Henry E. Purple  
836. Thomas F. Brown  
837. Alexander G. Green  
838. John H. Black  
839. Robert I. Grey  
840. David J. Pink  
841. John K. Blue  
842. William L. Yellow  
843. James M. Purple  
844. Charles N. Brown  
845. Edward O. Green  
846. George P. Black  
847. Henry Q. Grey  
848. Thomas R. Pink  
849. Alexander S. Blue  
850. John T. Yellow  
851. Robert U. Purple  
852. David V. Brown  
853. John W. Green  
854. William X. Black  
855. James Y. Grey  
856. Charles Z. Pink  
857. Edward A. Blue  
858. George B. Yellow  
859. Henry C. Purple  
860. Thomas D. Brown  
861. Alexander E. Green  
862. John F. Black  
863. Robert G. Grey  
864. David H. Pink  
865. John I. Blue  
866. William J. Yellow  
867. James K. Purple  
868. Charles L. Brown  
869. Edward M. Green  
870. George N. Black  
871. Henry O. Grey  
872. Thomas P. Pink  
873. Alexander Q. Blue  
874. John R. Yellow  
875. Robert S. Purple  
876. David T. Brown  
877. John U. Green  
878. William V. Black  
879. James W. Grey  
880. Charles X. Pink  
881. Edward Y. Blue  
882. George Z. Yellow  
883. Henry A. Purple  
884. Thomas B. Brown  
885. Alexander C. Green  
886. John D. Black  
887. Robert E. Grey  
888. David F. Pink  
889. John G. Blue  
890. William H. Yellow  
891. James I. Purple  
892. Charles J. Brown  
893. Edward K. Green  
894. George L. Black  
895. Henry M. Grey  
896. Thomas N. Pink  
897. Alexander O. Blue  
898. John P. Yellow  
899. Robert Q. Purple  
900. David R. Brown  
901. John S. Green  
902. William T. Black  
903. James U. Grey  
904. Charles V. Pink  
905. Edward W. Blue  
906. George X. Yellow  
907. Henry Y. Purple  
908. Thomas Z. Brown  
909. Alexander A. Green  
910. John B. Black  
911. Robert C. Grey  
912. David D. Pink  
913. John E. Blue  
914. William F. Yellow  
915. James G. Purple  
916. Charles H. Brown  
917. Edward I. Green  
918. George J. Black  
919. Henry K. Grey  
920. Thomas L. Pink  
921. Alexander M. Blue  
922. John N. Yellow  
923. Robert O. Purple  
924. David P. Brown  
925. John Q. Green  
926. William R. Black  
927. James S. Grey  
928. Charles T. Pink  
929. Edward U. Blue  
930. George V. Yellow  
931. Henry W. Purple  
932. Thomas X. Brown  
933. Alexander Y. Green  
934. John Z. Black  
935. Robert A. Grey  
936. David B. Pink  
937. John C. Blue  
938. William D. Yellow  
939. James E. Purple  
940. Charles F. Brown  
941. Edward G. Green  
942. George H. Black  
943. Henry I. Grey  
944. Thomas J. Pink  
945. Alexander K. Blue  
946. John L. Yellow  
947. Robert M. Purple  
948. David N. Brown  
949. John O. Green  
950. William P. Black  
951. James Q. Grey  
952. Charles R. Pink  
953. Edward S. Blue  
954. George T. Yellow  
955. Henry U. Purple  
956. Thomas V. Brown  
957. Alexander W. Green  
958. John X. Black  
959. Robert Y. Grey  
960. David Z. Pink  
961. John A. Blue  
962. William B. Yellow  
963. James C. Purple  
964. Charles D. Brown  
965. Edward E. Green  
966. George F. Black  
967. Henry G. Grey  
968. Thomas H. Pink  
969. Alexander I. Blue  
970. John J. Yellow  
971. Robert K. Purple  
972. David L. Brown  
973. John M. Green  
974. William N. Black  
975. James O. Grey  
976. Charles P. Pink  
977. Edward Q. Blue  
978. George R. Yellow  
979. Henry S. Purple  
980. Thomas T. Brown  
981. Alexander U. Green  
982. John V. Black  
983. Robert W. Grey  
984. David X. Pink  
985. John Y. Blue  
986. William Z. Yellow  
987. James A. Purple  
988. Charles B. Brown  
989. Edward C. Green  
990. George D. Black  
991. Henry E. Grey  
992. Thomas F. Pink  
993. Alexander G. Blue  
994. John H. Yellow  
995. Robert I. Purple  
996. David J. Brown  
997. John K. Green  
998. William L. Black  
999. James M. Grey  
1000. Charles N. Pink  
1001. Edward O. Blue  
1002. George P. Yellow  
1003. Henry Q. Purple  
1004. Thomas R. Brown  
1005. Alexander S. Green  
1006. John T. Black  
1007. Robert U. Grey  
1008. David V. Pink  
1009. John W. Blue  
1010. William X. Yellow  
1011. James Y. Purple  
1012. Charles Z. Brown  
1013. Edward A. Green  
1014. George B. Black  
1015. Henry C. Grey  
1016. Thomas D. Pink  
1017. Alexander E. Blue  
1018. John F. Yellow  
1019. Robert G. Purple  
1020. David H. Brown  
1021. John I. Green  
1022. William J. Black  
1023. James K. Grey  
1024. Charles L. Pink  
1025. Edward M. Blue  
1026. George N. Yellow  
1027. Henry O. Purple  
1028. Thomas P. Brown  
1029. Alexander Q. Green  
1030. John R. Black  
1031. Robert S. Grey  
1032. David T. Pink  
1033. John U. Blue  
1034. William V. Yellow  
1035. James W. Purple  
1036. Charles X. Brown  
1037. Edward Y. Green  
1038. George Z. Black  
1039. Henry A. Grey  
1040. Thomas B. Pink  
1041. Alexander C. Blue  
1042. John D. Yellow  
1043. Robert E. Purple  
1044. David F. Brown  
1045. John G. Green  
1046. William H. Black  
1047. James I. Grey  
1048. Charles J. Pink  
1049. Edward K. Blue  
1050. George L. Yellow  
1051. Henry M. Purple  
1052. Thomas N. Brown  
1053. Alexander O. Green  
1054. John P. Black  
1055. Robert Q. Grey  
1056. David R. Pink  
1057. John S. Blue  
1058. William T. Yellow  
1059. James U. Purple  
1060. Charles V. Brown  
1061. Edward W. Green  
1062. George X. Black  
1063. Henry Y. Grey  
1064. Thomas Z. Pink  
1065. Alexander A. Blue  
1066. John B. Yellow  
1067. Robert C. Purple  
1068. David D. Brown  
1069. John E. Green  
1070. William F. Black  
1071. James G. Grey  
1072. Charles H. Pink  
1073. Edward I. Blue  
1074. George J. Yellow  
1075. Henry K. Purple  
1076. Thomas L. Brown  
1077. Alexander M. Green  
1078. John N. Black  
1079. Robert O. Grey  
1080. David P. Pink  
1081. John Q. Blue  
1082. William R. Yellow  
1083. James S. Purple  
1084. Charles T. Brown  
1085. Edward U. Green  
1086. George V. Black  
1087. Henry W. Grey  
1088. Thomas X. Pink  
1089. Alexander Y. Blue  
1090. John Z. Yellow  
1091. Robert A. Purple  
1092. David B. Brown  
1093. John C. Green  
1094. William D. Black  
1095. James E. Grey  
1096. Charles F. Pink  
1097. Edward G. Blue  
1098. George H. Yellow  
1099. Henry I. Purple  
1100. Thomas J. Brown  
1101. Alexander K. Green  
1102. John L. Black  
1103. Robert M. Grey  
1104. David N. Pink  
1105. John O. Blue  
1106. William P. Yellow  
1107. James Q. Purple  
1108. Charles R. Brown  
1109. Edward S. Green  
1110. George T. Black  
1111. Henry U. Grey  
1112. Thomas V. Pink  
1113. Alexander W. Blue  
1114. John X. Yellow  
1115. Robert Y. Purple  
1116. David Z. Brown  
1117. John A. Green  
1118. William B. Black  
1119. James C. Grey  
1120. Charles D. Pink  
1121. Edward E. Blue  
1122. George F. Yellow  
1123. Henry G. Purple  
1124. Thomas H. Brown  
1125. Alexander I. Green  
1126. John J. Black  
1127. Robert K. Grey  
1128. David L. Pink  
1129. John M. Blue  
1130. William N. Yellow  
1131. James O. Purple  
1132. Charles P. Brown  
1133. Edward Q. Green  
1134. George R. Black  
1135. Henry S. Grey  
1136. Thomas T. Pink  
1137. Alexander U. Blue  
1138. John V. Yellow  
1139. Robert W. Purple  
1140. David X. Brown  
1141. John Y. Green  
1142. William Z. Black  
1143. James A. Grey  
1144. Charles B. Pink  
1145. Edward C. Blue  
1146. George D. Yellow  
1147. Henry E. Purple  
1148. Thomas F. Brown  
1149. Alexander G. Green  
1150. John H. Black  
1151. Robert I. Grey  
1152. David J. Pink  
1153. John K. Blue  
1154. William L. Yellow  
1155. James M. Purple  
1156. Charles N. Brown  
1157. Edward O. Green  
1158. George P. Black  
1159. Henry Q. Grey  
1160. Thomas R. Pink  
1161. Alexander S. Blue  
1162. John T. Yellow  
1163. Robert U. Purple  
1164. David V. Brown  
1165. John W. Green  
1166. William X. Black  
1167. James Y. Grey  
1168. Charles Z. Pink  
1169. Edward A. Blue  
1170. George B. Yellow  
1171. Henry C. Purple  
1172. Thomas D. Brown  
1173. Alexander E. Green  
1174. John F. Black  
1175. Robert G. Grey  
1176. David H. Pink  
1177. John I. Blue  
1178. William J. Yellow  
1179. James K. Purple  
1180. Charles L. Brown  
1181. Edward M. Green  
1182. George N. Black  
1183. Henry O. Grey  
1184. Thomas P. Pink  
1185. Alexander Q. Blue  
1186. John R. Yellow  
1187. Robert S. Purple  
1188. David T. Brown  
1189. John U. Green  
1190. William V. Black  
1191. James W. Grey  
1192. Charles X. Pink  
1193. Edward Y. Blue  
1194. George Z. Yellow  
1195. Henry A. Purple  
1196. Thomas B. Brown  
1197. Alexander C. Green  
1198. John D. Black  
1199. Robert E. Grey  
1200. David F. Pink  
1201. John G. Blue  
1202. William H. Yellow  
1203. James I. Purple  
1204. Charles J. Brown  
1205. Edward K. Green  
1206. George L. Black  
1207. Henry M. Grey  
1208. Thomas N. Pink  
1209. Alexander O. Blue  
1210. John P. Yellow  
1211. Robert Q. Purple  
1212. David R. Brown  
1213. John S. Green  
1214. William T. Black  
1215. James U. Grey  
1216. Charles V. Pink  
1217. Edward W. Blue  
1218. George X. Yellow  
1219. Henry Y. Purple  
1220. Thomas Z.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A S (4)  
15M 9/59

2313

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02291

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANDREWS AIR FORCE BASE</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF HOSP., ANDREWS AFB, WASH 25 DC</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>(DISTRICT OF COLUMBIA)</b> b. COUNTY <b>FANNING</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>14 WASHINGTON</b> d. STREET ADDRESS <b>6411 ABBINGTON DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ODESSA M THYRET</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 8 19 61</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 AUGUST 1903</b>
9. AGE (In years last birthday) <b>57 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	
13. FATHER'S NAME <b>WILLIAM M HERD</b>		14. MOTHER'S MAIDEN NAME <b>PEARL WEAR</b>	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>LORRINE O SCHOTTLEUTNER</b>		Address <b>SAME AS ITEM #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO <b>RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS, MITRAL INSUFFICIENCY AND AORTIC INSUFFICIENCY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>(b) (c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 YEARS</b> <b>26 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>STOCKTON, CALIFORNIA</b>		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8 FEBRUARY, 19 61</b> , to <b>8 FEBRUARY, 19 61</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8 FEBRUARY 1961</b> , and that death occurred at <b>3:27 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Andrew W. Butchko, Capt USAF MC</b>		22b. DATE <b>8 FEBRUARY 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ANDREW W BUTCHKO, CAPT USAF MC</b>		22d. ADDRESS <b>USAF HOSP., ANDREWS AFB, WASH 25, DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-10-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>RURAL MAUSOLEUM</b>		23d. LOCATION (City, town, or county) (State) <b>STOCKTON, CALIFORNIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley's Sons</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 14 '61</b>	
ADDRESS <b>1756 Pa. Ave. N.W. Wash D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	





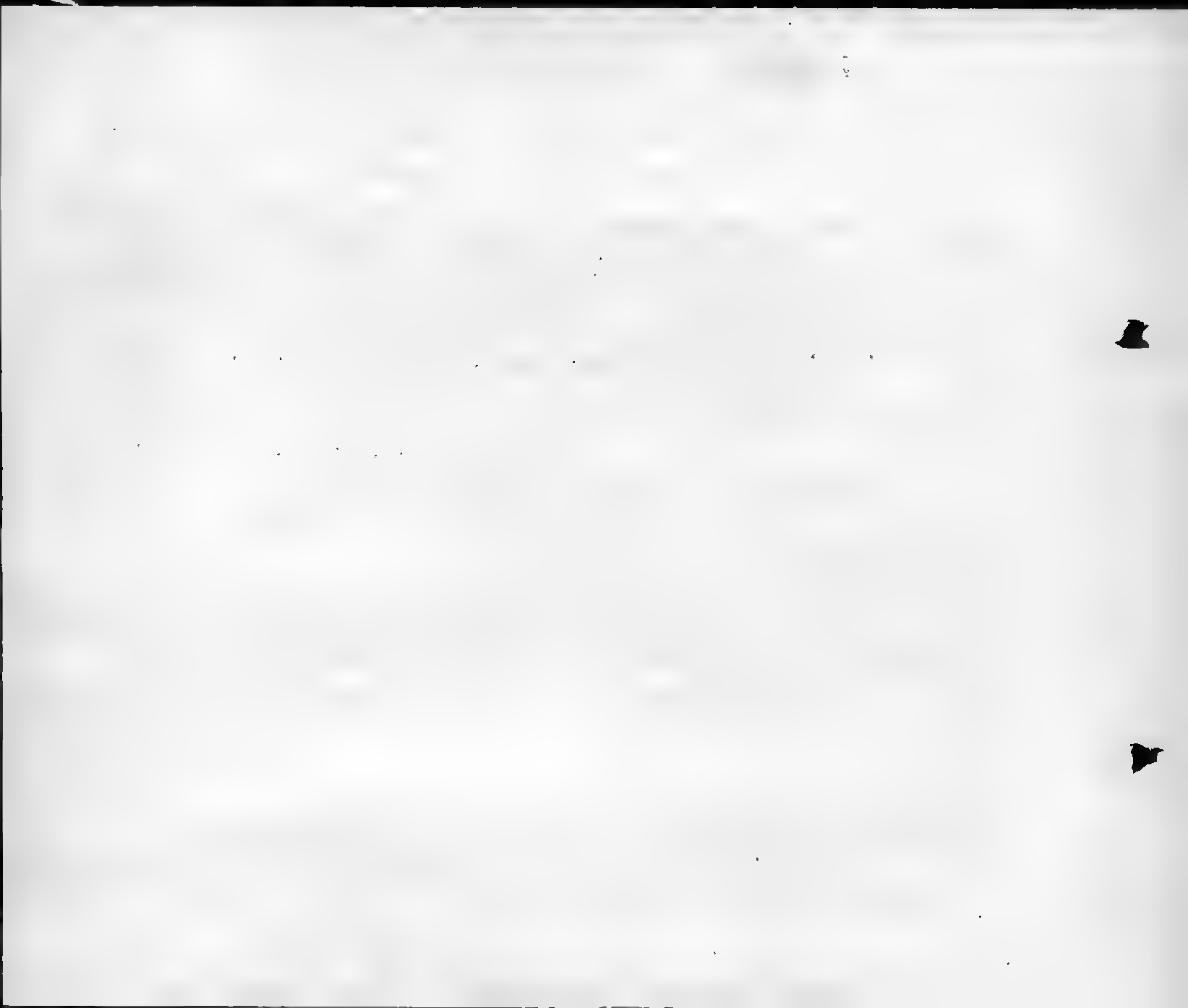
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

2314

0229

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>1/2 hr</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>7630 Oxman Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>MAYLON</u> Last <u>Turner</u>			<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>26</u> Year <u>19 61</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>22 May 1898</u>		<b>9. AGE</b> (In years lost birthday) <u>63</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ass. Mgr.</u>				<b>12. KIND OF BUSINESS OR INDUSTRY</b> <u>Charles Drug Store</u>			
<b>13. BIRTHPLACE</b> (State or foreign country) <u>Raleigh, N.C.</u>				<b>14. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>			
<b>15. FATHER'S NAME</b> <u>Unknown John Turner</u>				<b>16. MOTHER'S MAIDEN NAME</b> <u>Unknown Martha ?</u>			
<b>17. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		<b>18. SOCIAL SECURITY NO</b> <u>  </u>		<b>19. INFORMANT</b> <u>Paul C. Turner - Son</u> Address <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <u>  </u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>61</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/26</u> 19 <u>61</u> <b>to</b> <u>2/26</u> 19 <u>61</u> <b>that (I) (we) last saw the deceased alive on</b> <u>2/26</u> 19 <u>61</u> <b>and that death occurred at</b> <u>11 PM</u> <b>from the causes and on the date stated above.</b>					
<b>22a. SIGNATURE</b> <u>Norman D. Donat</u> M.D.				<b>22b. DATE SIGNED</b> <u>  </u>			
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Norman D. Donat</u>				<b>22d. ADDRESS</b> <u>3503 Penny St Mt Rainier Md</u>			
<b>23a. BURIAL, CREMATION REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>3/3/61</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln</u>			
<b>23d. LOCATION</b> (City, town, or county) <u>Colmar Manor, Md.</u> (State) <u>  </u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Halley's Funeral Home Inc.</u>					
<b>25a. REC'D BY REGISTRAR</b> DATE <u>MAR 6 '61</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Finner</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

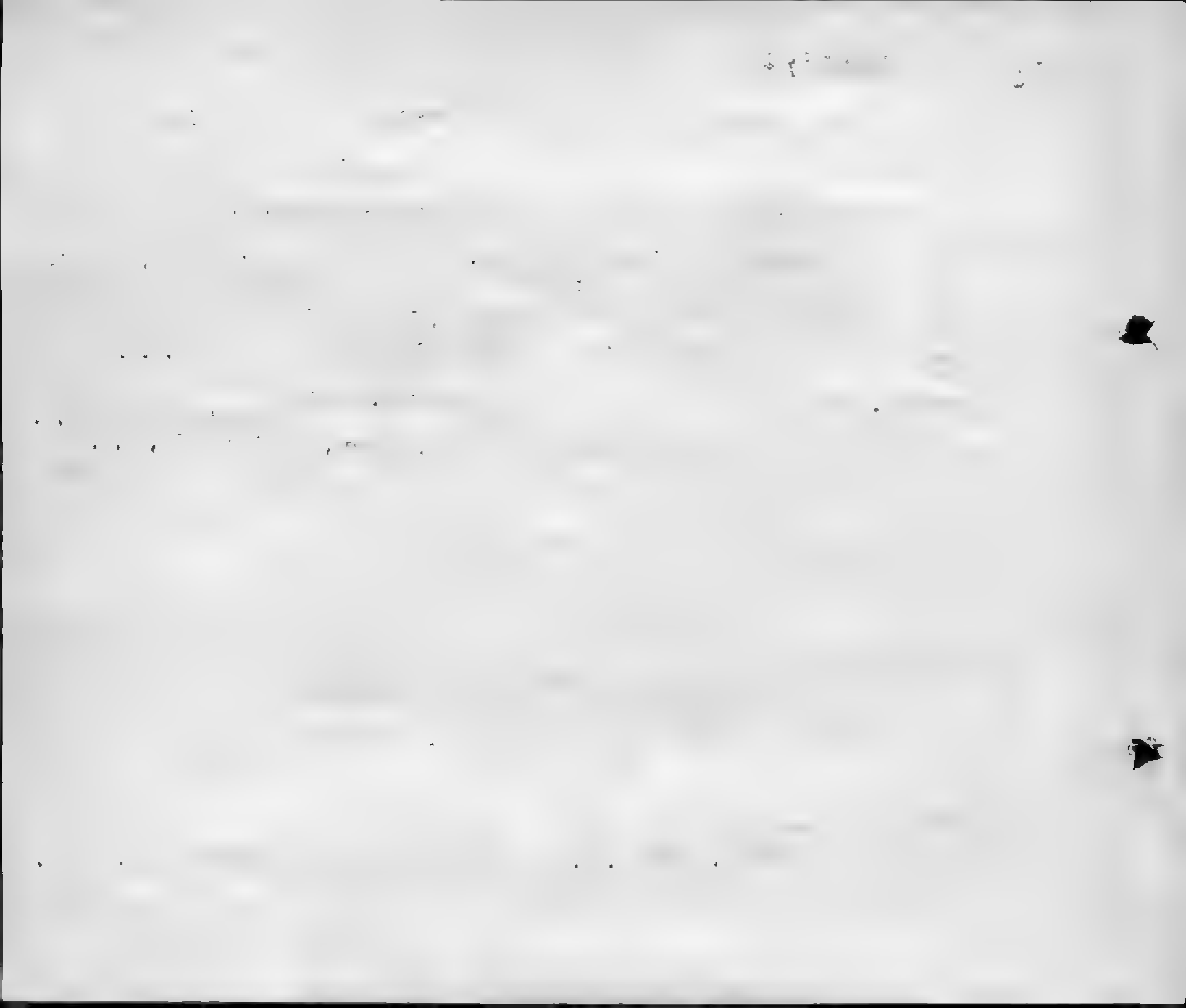
VS. A15ME  
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
2315 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02293									
1. PLACE OF DEATH a. COUNTY <u>Prince Georges County</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if insttut on; Res dence before adm ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS <u>4102 Cottage Terrace</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospita, g ve street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>SARAH ELIZABETH WATERS</u>					4. DATE OF DEATH <u>February 23, 19 61.</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>August 4, 1899</u>				
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>Clerk</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Western Union</u>				
13. FATHER'S NAME <u>George W. Bladen</u>					14. MOTHER'S MAIDEN NAME <u>Margaret A. Seek</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>578-10-8556</u>				
17. INFORMANT <u>Mrs Ellen B. Holmes</u>					18. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>				
DUE TO (b) <u>Universal First, Second and third degree</u>									
DUE TO (c) <u>Universal First, Second and third degree</u>									
PART II. OTHER SIGNIFICANT CONDIT ONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OF CONTRIBUTING CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>In house that burned</u>				
20c. TIME OF INJURY Month, Day, Year <u>5 2-23-19 61</u>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>					20f. (City or town) <u>Cottage City, P.G., Md</u> (State) <u>Md</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>James I. Boyd</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JAMES I. BOYD, M. D.</u>					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					Address (Street, city, town, or county) <u>February 23, 1961.</u>				
22a. BURIAL, CREMATION, REMOVAL, Spec by <u>Burial</u>					22b. DATE THEREOF <u>2-25-1961</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>					22d. LOCATION (City, town, or county) <u>Suitland, Maryland</u> (State) <u>Md</u>				
23. FUNERAL DIRECTOR <u>W. W. Chambers Co. Funeral Directors, Md</u>					24. REC'D BY REGISTRAR <u>March 1 '61</u>				
					24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hauer</u>				

16

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

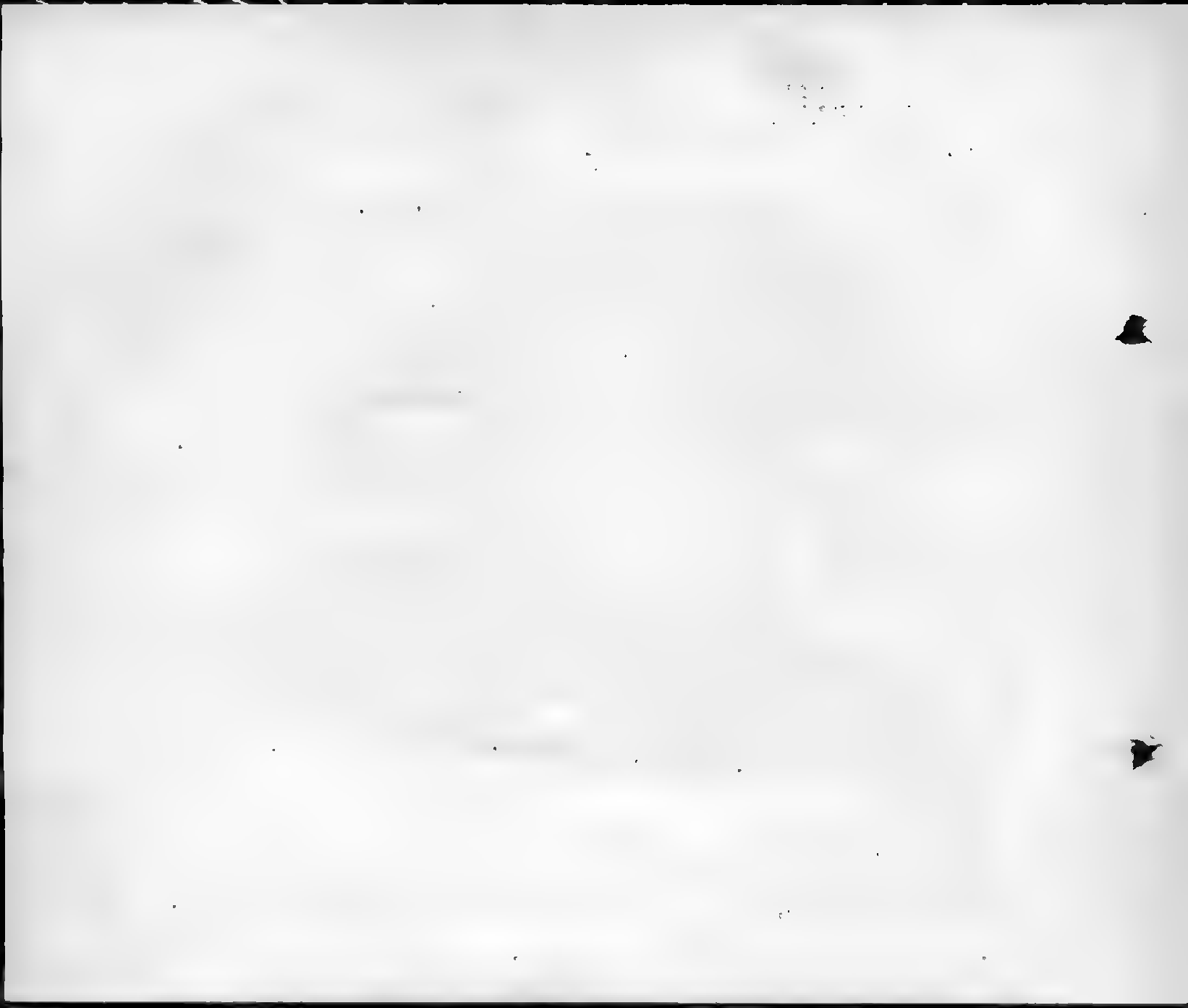
VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

2316

02294

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>7 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East Pines</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General Hospital</b>				d. STREET ADDRESS <b>5819 66th Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Augusta</b> Last <b>Watts</b>				4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>1961</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1905</b>		9. AGE (In years last birthday) <b>55</b> yrs	IF UNDER 1 YEAR Months <b>5</b> Days <b>5</b>	IF UNDER 24 HRS Hours <b>1</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Edward Hutchinson</b>				14. MOTHER'S MAIDEN NAME <b>Effie Simpson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>George A Watts East Pines Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Broncho pneumonia Rt + Left L. lung</b> <b>420.0</b> DUE TO <b>Cerebral infarct Left R. 1 day</b> Conditions, if any, which gave rise to immediate cause (a); stating the underlying cause last (b) <b>Arterioscl. Ht. dis.</b> (c) <b>undet</b>							INTERVAL BETWEEN ONSET AND DEATH <b>undet</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>1961</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 15</b> <b>1961</b> to <b>Feb. 22</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>Feb. 22</b> <b>1961</b> , and that death occurred at <b>8:30</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Benjamin S Miller</b>				22b. DATE SIGNED <b>Feb. 22 1961</b>		22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN S MILLER</b>	
22d. ADDRESS <b>3824-34th Mt Rainier</b>				22e. DATE <b>FEB 27 '61</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 25, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Colmar Manor, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland.</b>		25a. REC'D BY REGISTRAR <b>FEB 27 '61</b>	
				25b. REGISTRAR'S SIGNATURE <b>Colman S. Thomas</b>			



## CERTIFICATE OF DEATH

Reg. Dist. No. 02295

2317

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Adelphi</u>		c. LENGTH OF STAY IN 1b <u>10 1/2 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie</u> First <u>(none)</u> Middle <u>Whaley</u> Last		4. DATE OF DEATH <u>February 18</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Hampton</u>		14. MOTHER'S MARRIAGE NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Records of Point Branch Nurs. Home</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>cerebral vascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>cerebral arteriosclerosis</u> DUE TO <u>generalized arteriosclerosis</u> (c) <u>10 years</u> <u>15 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 18, 1961</u> to <u>February 18, 1961</u> that I last saw the deceased alive on <u>February 18, 1961</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hans Wodak</u>		ADDRESS (Street, city or town, state) <u>4-E PARKWAY, GREENBELT, MD 20814</u>	
PHYSICIAN'S NAME (Type) <u>HANS WODAK M.D.</u>		ADDRESS <u>9-E PARKWAY, GREENBELT, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-21-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington, D.C.</u>		ADDRESS <u>558 21 '61</u>	
24a. REC'D BY REGISTRAR <u>558 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2318

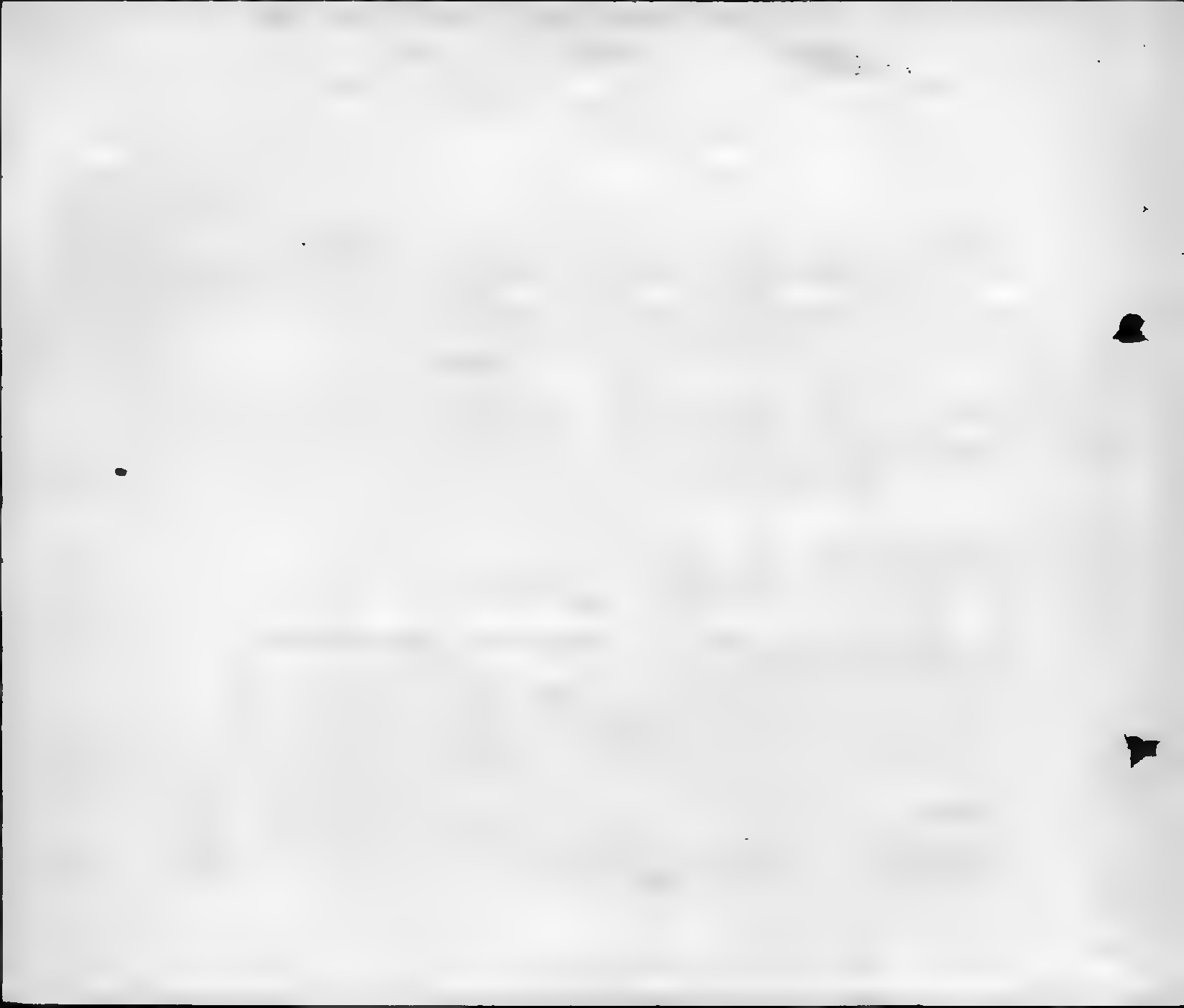
CERTIFICATE OF DEATH

Reg. Dist. No. 11229

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. G. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8320 Old Fort Rd SE</u>				e. STREET ADDRESS <u>18320 Old Fort Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>White</u> Last <u>White</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u> <u>1893</u> <u>68?</u> yrs.	9. AGE (In years last birthday) <u>68?</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>UNK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or, unknown) (If yes, give war or dates of service) <u>UNK</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>ROSALIE JACKSON, 8320 Old Ft. Rd. WASH., D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decompensation</u> DUE TO (c) <u>Hypertensive Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>24 hrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemiplegia 1957</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/13</u> , 19 <u>57</u> to <u>2/2</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb. 2</u> , 19 <u>61</u> , and that death occurred at <u>7:45 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Anna Coyne Todd</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>7519 Broadview Rd S.E.</u> <u>2/2/61</u>			
PHYSICIAN'S NAME (Type) <u>Anna Coyne Todd</u>				(Pr. Geo. County Md) <u>Waldorf</u> <u>2/2/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-7-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Walders Field</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HUNTT Funeral Home, WALDORF, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 1961</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1 and 3 to the funeral director. Pages 4 and 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

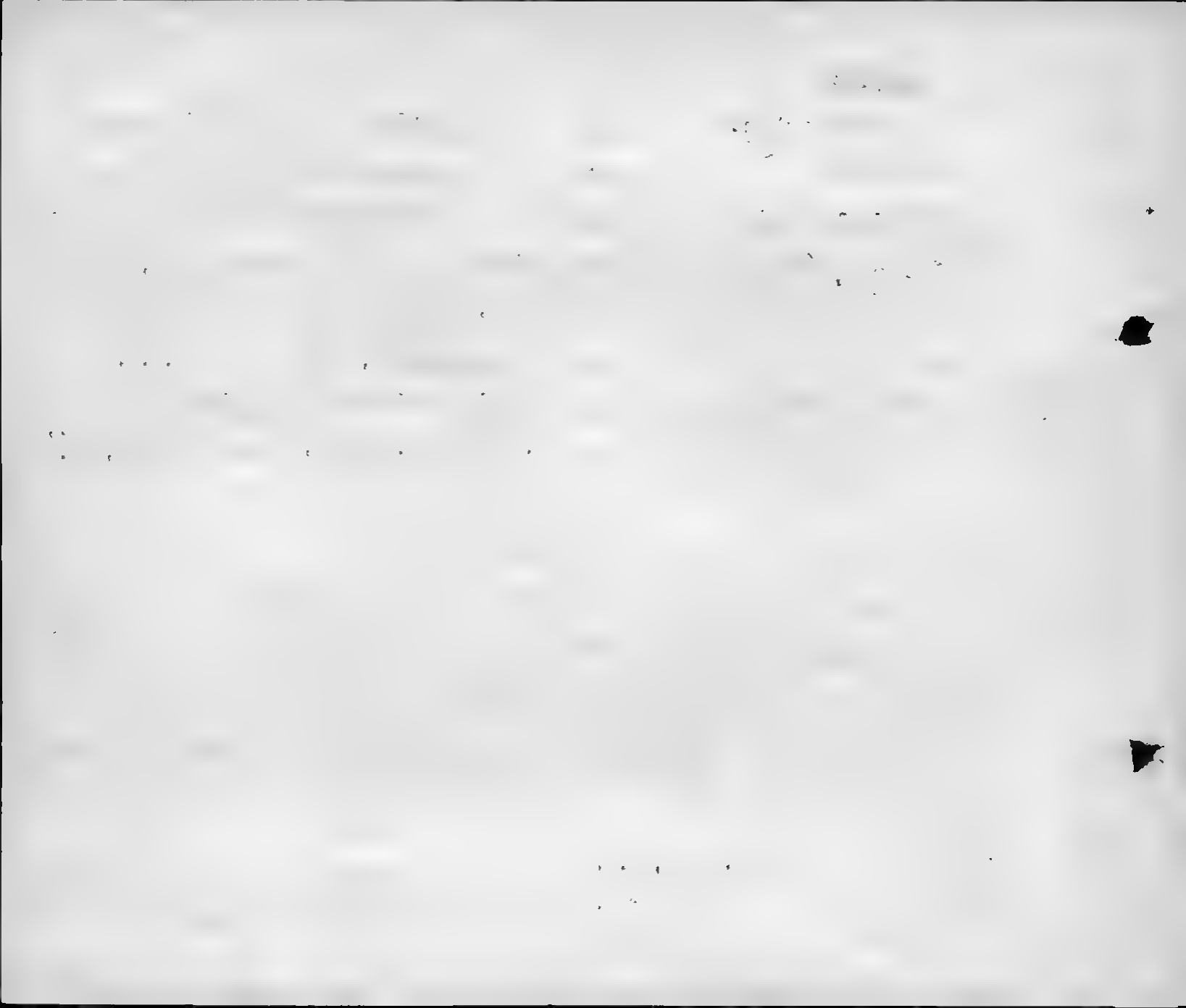
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2319

02294

1. PLACE OF DEATH a. COUNTY <b>Prince Georges County</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>College Park</b> c. LENGTH OF STAY IN b <b>3 Years</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4902 Quebec Street</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>College Park</b> d. STREET ADDRESS <b>4902 Quebec Street</b>	
3. NAME OF DECEASED (Type or print) <b>GLORIA BERNADINE WIEDEL</b>		4. DATE OF DEATH Month Day Year <b>February 13, 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <b>May 4, 1930</b>	
9. AGE (in years last birthday) <b>30 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours M.n. <b>30</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Branchville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul Edward Dement</b>		14. MOTHER'S MAIDEN NAME <b>Viola Elizabeth DeVilbliss</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>Mr. Kenneth E. Wiedel,</b>	
17. INFORMANT <b>Mr. Kenneth E. Wiedel,</b>		Address <b>4902 Quebec St., College Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>HANGING</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hanged self from water pipe in basement</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self from water pipe in basement</b>	
20c. TIME OF INJURY Month, Day, Year <b>4 P.M. 2-14-1961</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>College Park P.G. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b> EXAMINER'S NAME (Type) <b>JAMES I. BOYD, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>February 13, 1961</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-17-1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem</b>		22d. LOCATION (City, town, or country) (State) <b>Bladensburg, Maryland</b>	
23. FUNERAL DIRECTOR <b>W.W. Chambers Co. Riverdale, Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 17 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>			

MEDICAL CERTIFICATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2320

## CERTIFICATE OF DEATH

Reg. Dist. No. 2298

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>College Park, Md</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5009 Cheyenne Place</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Lawrence</b> Last <b>Wilkins</b>				4. DATE OF DEATH Month <b>Feb</b> Day <b>8</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec 3, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>67</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		12. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dept of Agriculture</b>			
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Robert M Wilkins</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mc Nary</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO <b>none</b>			
17. INFORMANT <b>Irene D Wilkins</b>				Address <b>College Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>diabetes mellitus</b>							
19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>8 Feb</b> , 1961, to <b>8 Feb</b> , 1961, that I last saw the deceased alive on <b>8 Feb</b> , 1961, and that death occurred at <b>9:05 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED <b>7812 49TH AVE 9 FEB 1961</b>							
ACTUAL SIGNATURE <b>H David Kerr MD</b> M.D.							
PHYSICIAN'S NAME (Type) <b>H. DAVID KERR MD</b> <b>College Park Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>							
22b. DATE THEREOF <b>Feb 13, 1961</b>							
22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National</b>							
22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F. Gasch's Sons Hyattsville, Maryland.</b>							
24a. REC'D BY REGISTRAR <b>FEB 10 '61</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thrash</b>							

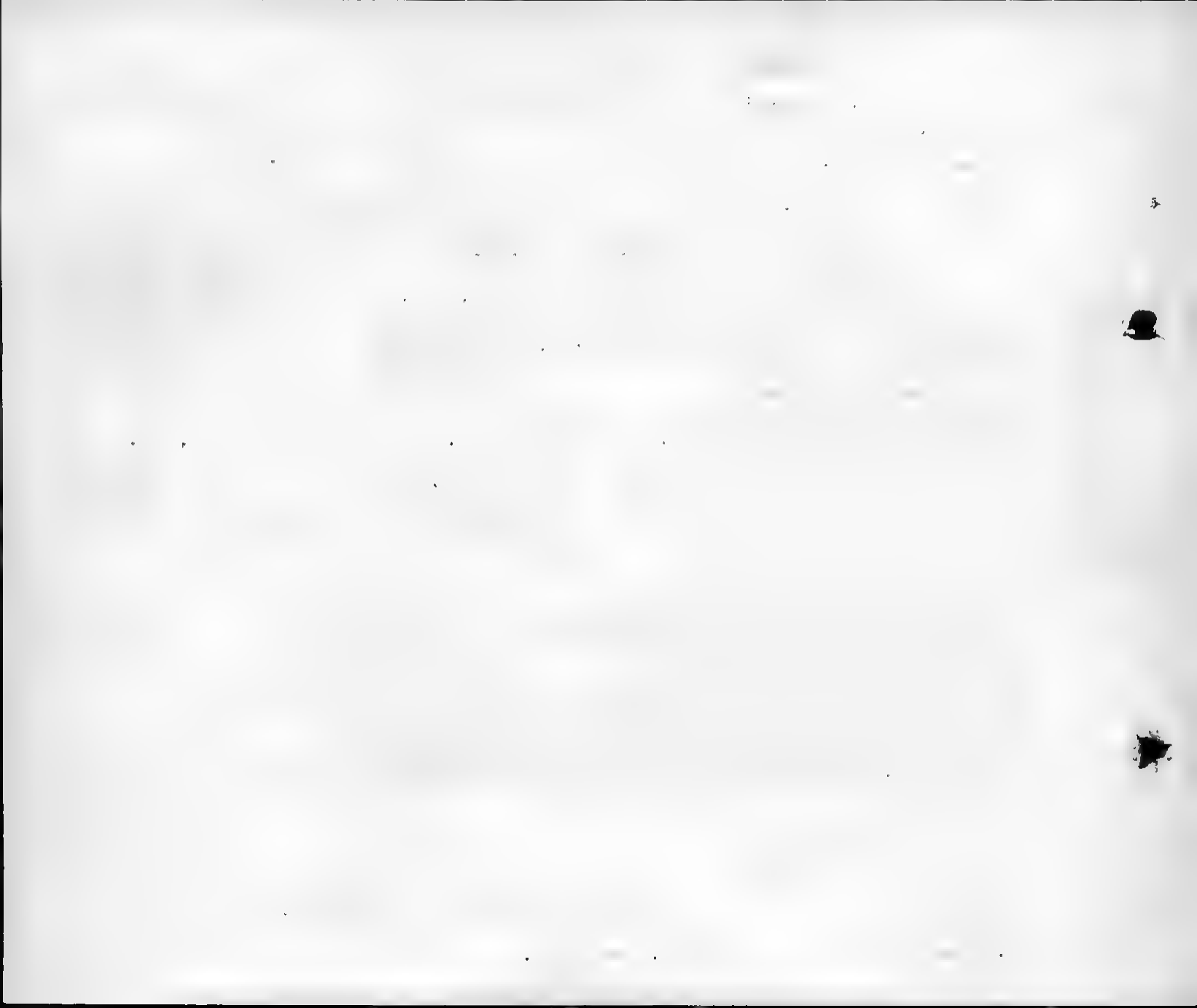
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

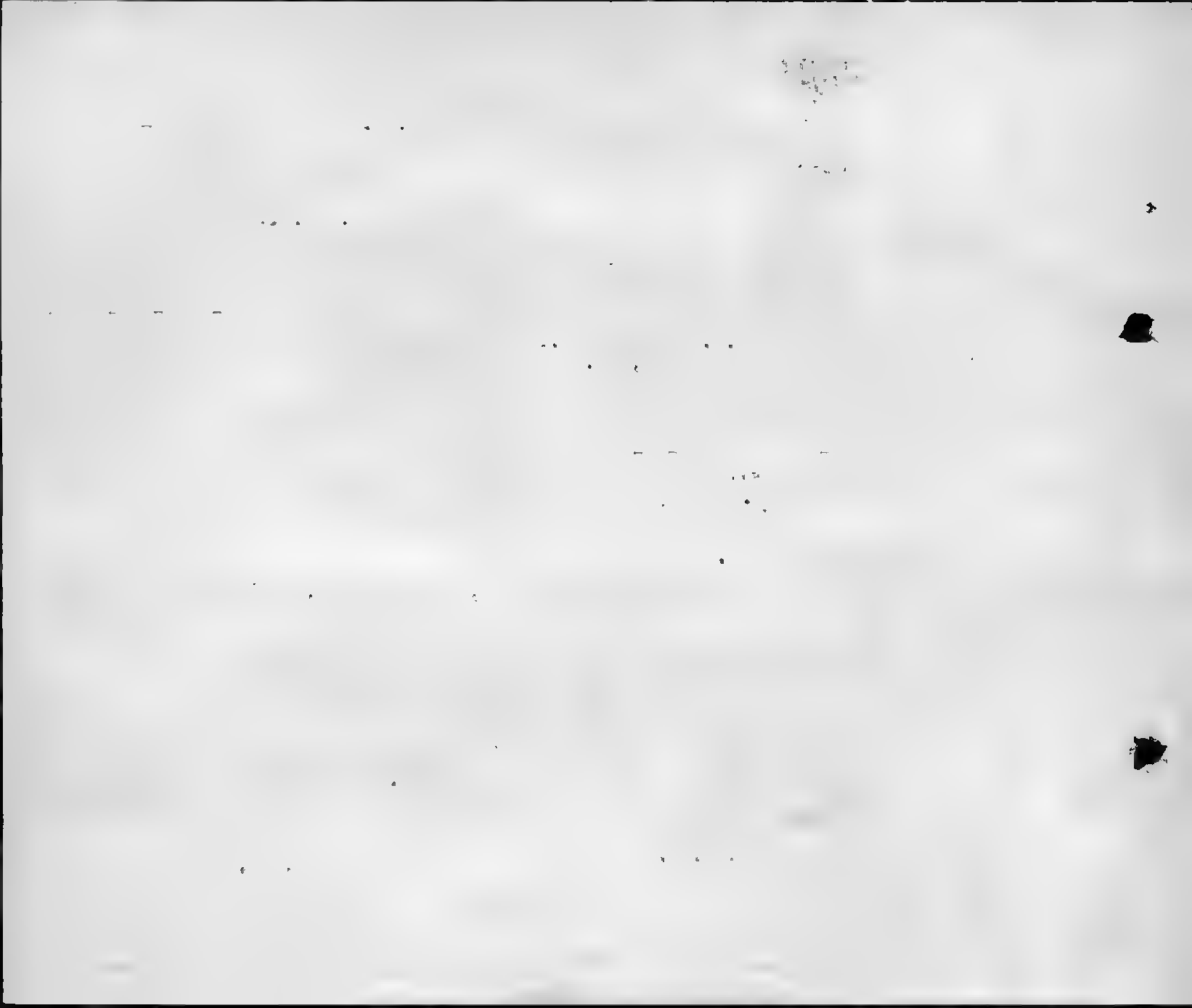
VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

2321

02293

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>1701 Swann St., N.W., Apt #26</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Wesley Williams</b>		4. DATE OF DEATH Month Day Year <b>2 22 19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/13/18</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		9. AGE (In years last birthday) <b>42 yrs.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>M.T. Broyhill Co.,</b>		11. BIRTHPLACE (County & State, or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>Wesley Williams</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>238-20-0053</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive hemoptysis</b> DUE TO (b) <b>002X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Pulmonary tuberculosis, far advanced, active</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>			
16 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>5/9 4:50 1960</b> to <b>2/22 1961</b> , that (I) (we) last saw the deceased alive on <b>2/22 1961</b> , and that death occurred at <b>4:50</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>2/22/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE THEREOF <b>2/24 61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Unknown</b>	23d. LOCATION (City, town or county) (State) <b>Smithfield N.C.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. N. Horton</b>		25a. REC'D BY REGISTRAR <b>322 York St. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>		DATE <b>FEB 27 '61</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2322

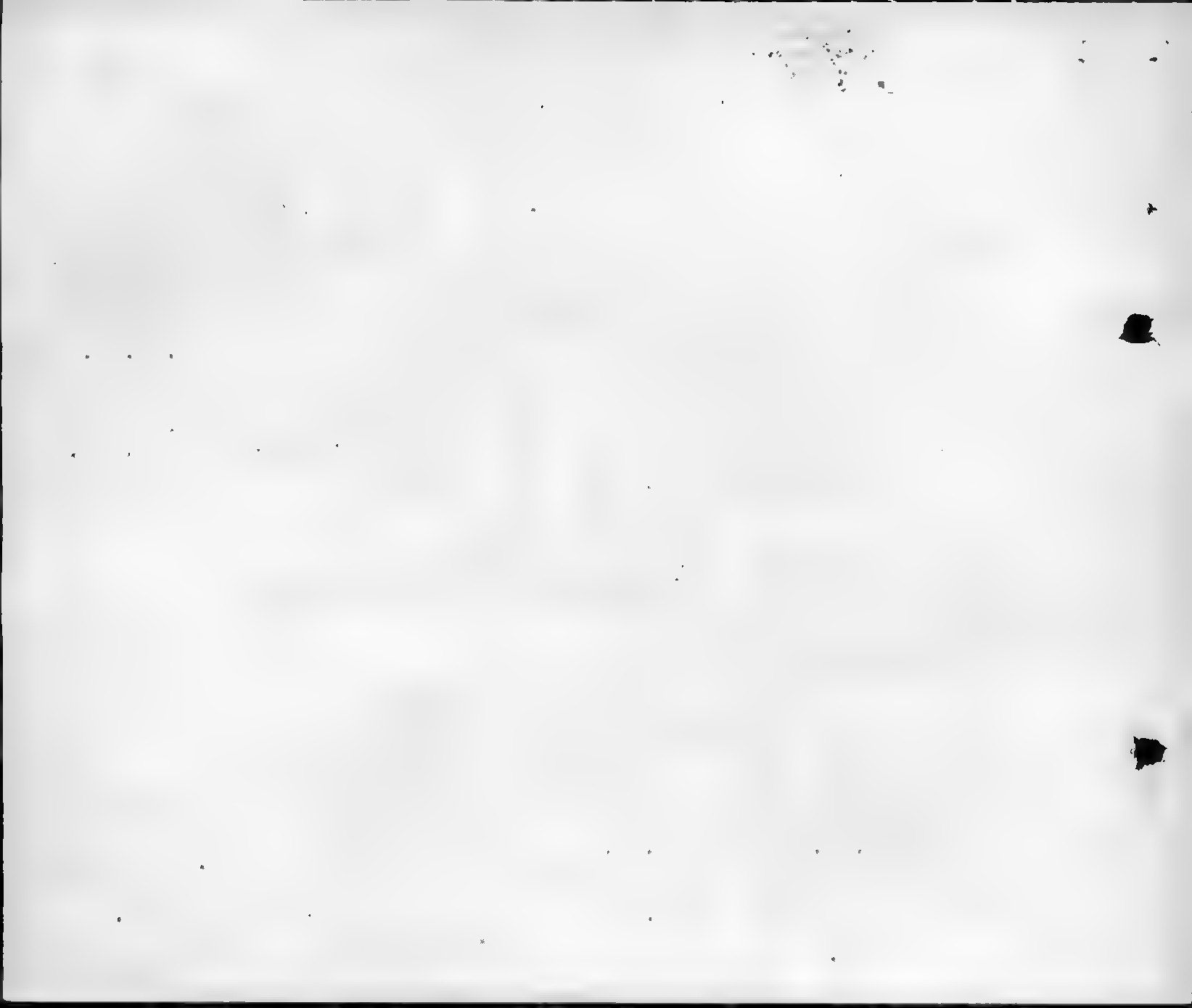
DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

03510

1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>2 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>G.</u> Last <u>WINDSOR</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-7-90</u>	
9. AGE (in years last birthday) <u>70</u> yrs		IF UNDER 1 YEAR Months <u>70</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John Windsor</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen -----</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unk.</u> (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO <u>214-12-747444</u>			
17. INFORMANT <u>Mrs. Irene Rawlings-Landover, Md.</u>				Address <u>Rt #1, Box 491</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Renal Failure</u> DUE TO (c) <u>Shock from Cerebral Vascular Accident</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>14 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m</u> <u>p. m</u> <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 29, 1961</u> , to <u>Feb. 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 11</u> <u>1961</u> and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>R. B. Sasser</u>				22b. DATE SIGNED <u>2/12/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. B. Sasser, M. D.</u>				22d. ADDRESS <u>Upper Marlboro, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Croom Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Upper Marlboro</u>				25a. REC'D BY REGISTRAR <u>MAR 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

1

I



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

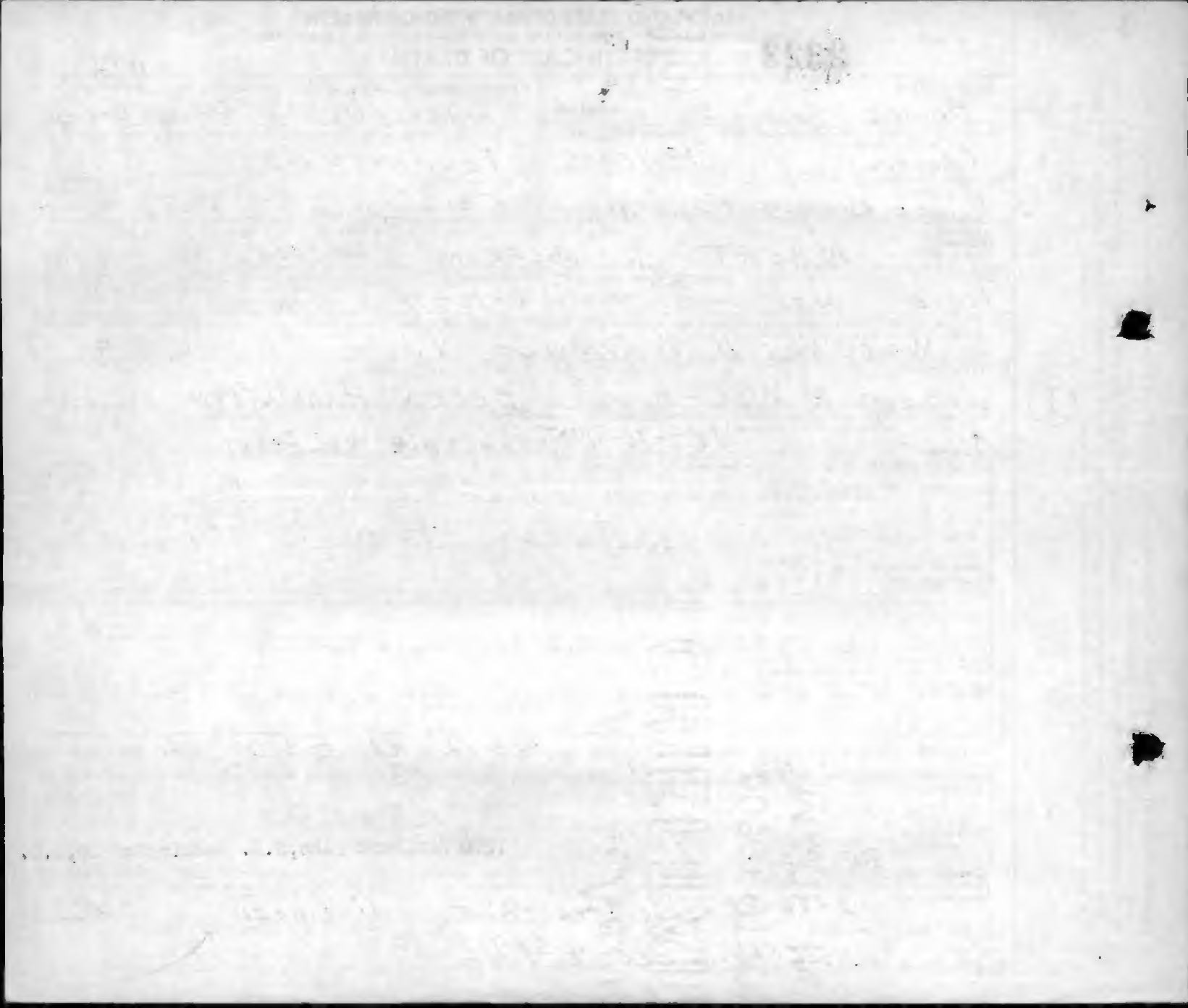
1 **MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**2323 CERTIFICATE OF DEATH**

02301

1. PLACE OF DEATH a. COUNTY <b>PRINCE George's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>13 YEARS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORRESTVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George's General</b>				d. STREET ADDRESS <b>5312 Spring St. S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>J.</b> Last <b>WOLFROM</b>				4. DATE OF DEATH Month <b>FEB.</b> Day <b>17</b> Year <b>1961</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-10-11</b>	
9. AGE (In years lost birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months <b>49</b> Days <b>17</b> Hours <b>19</b> Min.		11. BIRTHPLACE (State or foreign country) <b>N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WORKER II, Bricklayer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>N.J.</b>			
13. FATHER'S NAME <b>Joseph A. WOLFROM</b>				14. MOTHER'S MAIDEN NAME <b>ELLEN HARRINGTON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>				16. SOCIAL SECURITY NO. <b>198-10-319</b>		17. INFORMANT <b>Mrs. EUGENIA WOLFROM</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertension with ASclerotic Ht. d.</b> DUE TO (c) <b>ASclerotic Ht. d.</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 12, 1961</b> , to <b>FEB. 17, 1961</b> , that (I) (we) last saw the deceased alive on <b>FEB. 17, 1961</b> , and that death occurred at <b>10:20 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>DR. Sidney Lowry</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>DR. SIDNEY LOWRY</b>	
22d. ADDRESS <b>1200 Marlboro Pike, S.E. Washington 28, D.C.</b>				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-21-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>				25a. REC'D BY REGISTRAR <b>FEB 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

2

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
8  
M  
X  
I

2324

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02302

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>73</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10128 RIGGS ROAD</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>	
3. NAME OF DECEASED (Type or print) First <u>CAROLINE</u> Middle <u>L.</u> Last <u>YOBST</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 26, 1889</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY KERN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE YOGEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>VIVIAN YOBST</u>		Address <u>10128 RIGGS ROAD HYATTSVILLE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> <u>443X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of uterus</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 24, 1960</u> to <u>Feb. 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1961</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas J. Kelly</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS J. KELLY, M.D.</u>		22d. ADDRESS <u>64807 H. Ave., Takoma Park, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-27-61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>East Lincoln</u>		23d. LOCATION (City, town, or county) (State) <u>Calverton Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>See Funeral Home 300-4 St N.E. Wash D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 27 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>		25c. DATE	

1958